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ED 1.310/2:284387

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RESEARCH REPORT #10

AN ECOLOGICAL INVESTIGATION OF ASSESSMENT AND DECISION MAKING FOR HANDICAPPED CHILDREN PRIOR TO SCHOOL ENTRANCE

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EARLY CHILDHOOD ASSESSMENT PROJECT

September, 1986

EC 200204

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Abstract

Naturalistic procedures and a case study approach were used to study and describe four early childhood special education programs and their decision-making processes. Data collection procedures included (a) observations of meetings, classroom activities, screening, and assessment procedures, (b) extensive interviews with various staff and administrative personnel, (c) file searches, and (d) parent surveys. Detailed information is presented on preschool screening, diagnostic assessment procedures, instructional programs, program exit procedures, and follow-up data. This information formed the basis for future policy analyses.

The development of this report was supported by Grant No. G008400652 from Special Education Programs, U.S. Department of Education. Points of view or opinions stated in this report do not necessarily represent official position of Special Education Programs. Special appreciation is expressed to the school personnel, parents, and children who participated in the case studies.

DOCUMENT RESUME

ED 284 387 EC 200 204

AUTHOR	Ysseldyke, James E.; And Others
TITLE	An Ecological Investigation of Assessment and Decision Making for Handicapped Children Prior to School Entrance. Research Report #10. Early Childhood Assessment Project.
INSTITUTION	Minnesota Univ., Minneapolis.
SPONS AGENCY	Special Education Programs (ED/OSERS), Washington, DC.
PUB DATE	Sep 86
GRANT	G008400652
NOTE	220p.; Portions of document contain small print. For other reports in this series, see EC 200 205-209.
PUB TYPE	Reports - Descriptive (141) -- Reports - Research/Technical (143)
EDRS PRICE	MF01/PC09 Plus Postage.
DESCRIPTORS	Case Studies; *Decision Making; *Disabilities; Early Childhood Education; *Educational Diagnosis; *Handicap Identification; Institutional Characteristics; Intervention; Program Descriptions; Referral; Regional Characteristics; *School Policy; Screening Tests; *Special Education; Student Evaluation; Student Placement

ABSTRACT

This report documents a study which used naturalistic procedures and a case study approach to examine and describe four early childhood special education programs and their decision making processes. Data collection procedures included: observation of meetings, classroom activities, screening, and assessment procedures; interviews with various staff and administrative personnel; file searches; and parent surveys. Descriptions of each school program site include information on institutional characteristics, funding, screening and referral processes and decisions, diagnosis, intervention procedures, placement, and exit and follow-up procedures. Findings indicate that "Program A" reflected a systematic approach featuring short-term, data-based intervention designed to meet the needs of a large urban population. "Program B" offered an interdisciplinary, comprehensive, well-planned screening and intervention program for pre-kindergarten youngsters. "Program C" used a sophisticated, data-based approach to decision making for screening, referral, diagnostic assessment, intervention, and exit featuring qualified personnel and dynamic leadership. "Program D" reflected adaptations involved in providing services in a rural area where the relatively low incidence of handicapping conditions makes services harder to obtain. References are included and appendices contain parent surveys, meeting summaries, evaluative instruments, and other forms and materials used by the four programs. (CB)

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Chapter 1

Introduction

Martha L. Thurlow and James E. Ysseldyke

Research efforts of the Early Childhood Assessment Project at the University of Minnesota have focused during the past two years on the social, political, economic, and educational implications of alternative assessment and decision-making approaches for the process of identifying young children as handicapped and providing special education services to them. This research report presents the results of a naturalistic investigation of the assessment and decision-making process as it relates to preschool special education programs; the investigation was conducted in four early childhood special education programs. The major objective was to study and describe the programs and their decision-making processes in detail using naturalistic procedures and a qualitative case study approach, with the goal being a policy analysis of implications derived from integrating all findings.

Background

The amount of research that has been conducted on early identification and service provision has increased dramatically during the past decade, since services for young handicapped children (at least down to age 3) were included in Public Law 94-142. Before 1978, it was argued repeatedly that too many children were entering school with problems and/or handicaps that directly affected their capacity to learn (e.g., Cowen, Zax, Isso, & Trost, 1966; Davidson, Lichtenstein, Canter, & Cronin, 1977; Kurtz, Neisworth, & Laub, 1977; Lessler, 1972; Rogolsky, 1968; Roswell & Natchez, 1964). It also was suggested that problems exhibited by older children could have been recognized and remediated at an early age (e.g., deHirsch & Jansky, 1967; Fitzsimmons, Cheerer, Leonard, & Macunovich, 1969). Longitudinal studies, such as the Perry Preschool Project (Schweinhart & Weikart, 1981), in fact, indicated that early education significantly reduced the number of children who required special education services when they proceeded through elementary and secondary schools.

Although issues related to early childhood tests and education have been addressed by researchers and practitioners, little attention has been given to critical issues that surround the assessment and decision-making process. Furthermore, research to date has had limited implications for policy -- for deciding who gets services, what services are provided, who makes the decisions, and what the appropriate decisions are.

During the first year of funding, the Early Childhood Assessment Project focused research efforts on describing the current status of early childhood special education programs and preschool screening programs. The findings of the primary research activities are summarized briefly here.

Preschool screening and referral. Data from state department screening forms were available for 45,513 children in 402 school districts. Analyses revealed large variability in the rates of problem identification (0-100%, with an average of 31.2%) and referral (0-85.7%, with an average of 24.3%). Problems were identified and referrals made most often in the developmental areas, especially in speech/language. Boys were identified as having problems more often and were referred more often than girls. (See Thurlow, Ysseldyke, & O'Sullivan, 1985, for complete report.)

The results of screening were analyzed to estimate the relationship between referral rates and various social, economic, and educational characteristics of school districts, as well as the extent to which the characteristics differentiated high and low referral rate districts. Factors derived from the various social, economic, and educational characteristics did not help predict the referral rates of school districts statewide nor did they differentiate the high and low referral rate districts. (See Ysseldyke & O'Sullivan, 1985, for details.)

These referral rates were compared to rates found three years earlier (see Bursaw & Ysseldyke, 1986). Although the overall average remained the same, large differences in rates between years were found within districts, ranging from -58.5 to +36.1. District-level socioeconomic, educational, and screening variables were not related to referral rate consistency.

An interview study of high and low referral rate districts was conducted next, to further explore the variance in referral rates among districts. On a wide variety of variables, high and low referral rates districts were similar to each other. A possible exception was the finding that high referral districts more often than low referral districts tended to grant more decision-making authority to speech clinicians and preschool teachers. (See Ysseldyke, Thurlow, Weiss, Lehr, & Bursaw, 1986, for additional findings.)

Diagnostic assessment. Current diagnostic assessment procedures and their relationship to the screening process were addressed in a survey that was completed by over 500 programs (Ysseldyke, Thurlow, O'Sullivan, & Bursaw, 1985). While there is almost an exclusive reliance on two tools for screening of developmental difficulties, different tools are used for diagnostic assessments, and these vary greatly among programs. In contrast, most programs use the same tool for screening and diagnosis in the areas of hearing and vision. Most criteria for screening referrals and special education eligibility appear to be normative in nature, although "clinical judgment" more often is cited as the decision factor related to the results of diagnostic assessments.

Surveys of model early childhood education programs across the nation provided additional information about the diagnostic assessment process and about how decisions are made about that process (Lehr, Ysseldyke, & Thurlow, 1986). These revealed that technical considerations are reported to play a large role in both the selection and the continued use of tests. Yet, most of the tests actually used are, when evaluated on the basis of information provided in the tests manuals, technically inadequate. Further, responses to the survey indicated that tests were used more frequently than other methods when making decisions about classification and placement, instructional planning, and pupil evaluation.

Instructional decision making. Intensive interviews of preschool teachers (Ysseldyke, Nania, & Thurlow, 1985) and a national survey of teachers serving preschool handicapped children (Thurlow, Nania, & Ysseldyke, 1986) were conducted. All respondents had been recommended as exemplary teachers by administrators in their districts. Results showed that there was not consensus among the teachers about how to evaluate students and make decisions in early education programs for handicapped youngsters. What teachers do in these program is very much like what elementary special education teachers do. Instructional decisions are based more heavily on behavioral observations than on data from systematic evaluations of student progress.

Exit. Information on exit criteria were obtained from 178 early childhood education programs for handicapped children in eight states. Over half of the respondents indicated that their programs had specific written exit criteria. The child's chronological age most often was listed as the basis for exit. Results from formal tests, exit decisions based on team staffing, the child's developmental skill level, and alternative program offerings were the next most frequently listed criteria. Programs without formal written exit criteria listed the availability of alternative programming and parental input as criteria more frequently than programs that had formal exit criteria. (See Thurlow, Lehr, & Ysseldyke, 1985, for additional information.)

Research Questions

The investigation of the assessment and decision-making process was structured by generating research questions within each of the major stages and decision-making points in the process from screening to exit and follow-up. A general flow chart of the process is shown in Figure 1. The major areas of focus for research questions were: (a) definitions and objectives, (b) timing and setting, (c) participants, (d) personnel or team meeting, (e) content, and (f) costs. The specific research questions that were used to guide the study are provided in Table 1. In addition, detailed program descriptions were developed. The major areas for these descriptions included (a) community characteristics, (b) physical setting, (c) organization and staff, (d) history rationale and philosophy, (e) other influences. and (f) funding. The guiding questions for generating the descriptions are presented in Table 2.

Procedure

Four school districts with programs serving preschool age special education students were identified and asked to participate in a large scale descriptive research project. The four sites were selected to reflect a range in demographic characteristics (including community characteristics, and size of program) and in approaches to diagnostic assessment. Also, because data collection procedures required extensive contact with the sites, proximity to the research center was also considered. All sites contacted agreed to participate in the research.

One research team member was assigned to each participating district and acted as primary contact person and data collector. Typically, more than one person collected data in each site. In three of the districts data collection took place during an eight-month period. Due to time and travel restrictions,

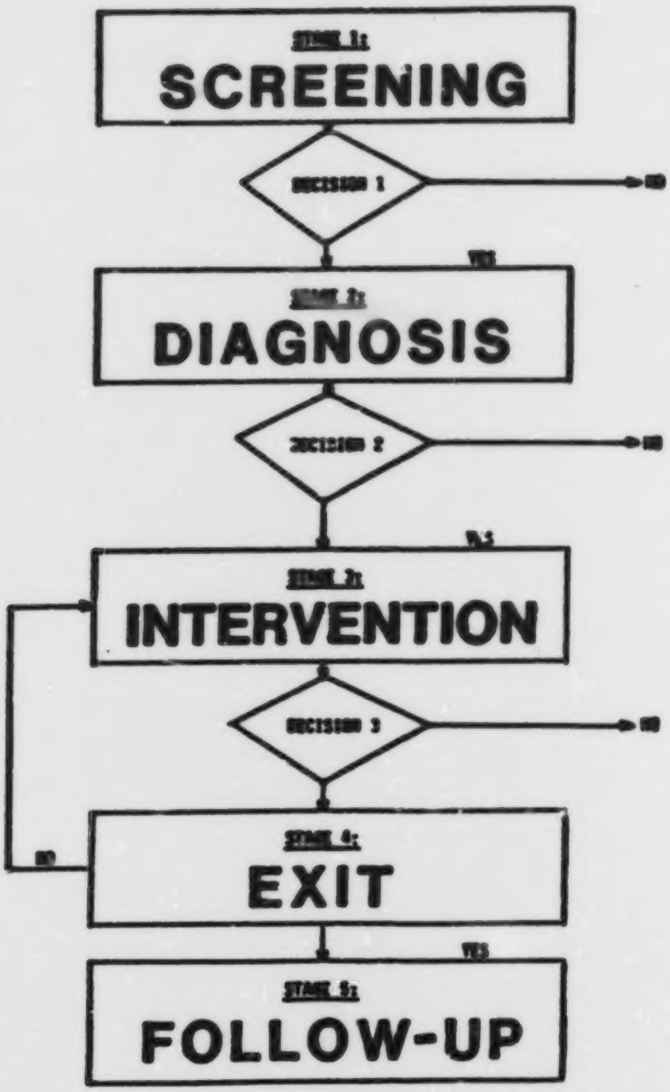
STAGE 1:
SCREENING
DECISION 1
NO
YES
STAGE 2:
DIAGNOSIS
DECISION 2
NO
YES
STAGE 3:
INTERVENTION
DECISION 3
NO
STAGE 4:
EXIT
NO
YES
STAGE 5:
FOLLOW-UP

Figure 1. Major Stages and Decision Points in the Early Childhood Special Education Assessment and Decision-Making Process.

Table 1

Research Questions Used to Study Programs

STAGE 1: SCREENING/REFERRAL

Definitions

What is the district's distinction between screening and assessment?
What is the district's objective for screening (e.g., to pick up all high risk kids, to find only kids with existing problems)?

Timing and Setting

When does screening occur?
Is screening periodic or continuous?
Is screening completed on a group or individual basis?
Where is screening conducted?
What is the average amount of screening time per child?

Participants

Who is notified about screening (and who is missed)?
How does the district find and contact families, with eligible children, who are new to the district?
How are people (parents and physicians) notified that screening will take place?
To what extent do community agencies refer children in for screening, and which ones do so?
What is the nature and extent of follow-up of children who are not brought in for screening?
At what ages are children screened?
If children of varying ages are screened, to what extent is the content of screening altered to the child's age?
What role do parents play in the screening process?
What feedback is given to parents, and when?
How does the screening process differ for mildly vs. severely handicapped children?
How many children are actually screened?
What percentage of eligible children actually are screened?
What are characteristics (age, sex, SES, race, parental occupation, etc.) of children who are screened vs. children who are not screened?

Personnel

What professionals participate in screening, and what is the role of each?
Who else (e.g., volunteers) participates in screening?
To what extent is there training of screening personnel, and what is the nature of training?
How satisfied are people with the tools/procedures used?

Content

What developmental areas are screened?
Are the same areas screened for all children?
Who decides what areas are screened?
What specific tools/procedures are used for screening in each area?
Are the same tools/procedures used for all children?
Who decides what tools/procedures are used?
How technically adequate are the tools/procedures used for screening?

Costs

How much does screening cost?

- Break down by personnel costs, materials costs, etc.

DECISION 1: SCREENING TO DIAGNOSTIC ASSESSMENT

Definitions

What is the district's definition of a referral for diagnostic assessment?
What is the district's definition of a rescreening?

Time and Setting

When is the screening pass/fail decision made?
When is the referral decision made?
Who makes the referral decision?

- If team makes decision, see "Team Meeting" questions

Besides failed preschool screenings, from where else are children referred?
What is the average decision-making time per child?

Table 1 - continued

Participants

How are parents notified of need for diagnostic assessment?
What role do parents play in the decision to conduct diagnostic assessments?
To where are children referred for diagnostic assessments?
What is the relationship between the referral area and the type of agency to which children are referred?
What are the characteristics (age, sex, SES, race, parental occupation, test scores) of children who are referred vs. children who are not referred for diagnostic assessment?
What proportion of children who are screened also are referred for further assessment?
Are there children who fail screening but do not get a diagnostic assessment?
How satisfied are people with the decision-making process?

Content

What information is used to decide that a referral is/is not warranted (qunatitative, qualitative)?
What proportion of time is spent discussing screening results, family history, extraneous issues, etc.?
Are there specific criteria for making referral decisions? What are they?
Is a specific reason for referral noted, or are referrals general?
To what extent and when are specific criteria ignored?
How often are children rescreened?
What proportion of screened children are rescreened?
What proportion of rescreened children end up being referred for diagnostic assessment?
Does the decision-making process differ for borderline cases?
Does the decision-making process differ for mild vs. severe cases?

Team Meeting

How many people attend the team meeting?
What areas of expertise do the people represent?
To what extent and when are nonprofessional and nonschool staff (parents, physicians, daycare teachers) included in the meeting?
How often are administrative personnel (preschool coordinators, principals) included?
What is the seating arrangement, and does it foster equal participation by all members?
Is a leadership role assigned to a particular staff member?
Does any member(s) dominate the meeting?
To what extent do parents and other nonschool individuals participate?
How many cases are discussed at the meeting?
How many minutes are spent discussing the average case, and what is the range of times?
What factors influence the duration of the decision-making process for each case?
To what extent is there time pressure on decision-making?
Are recommendations made for cases other than a referral decision? If so, what?
To what extent is there a standard format for discussing cases? What is it?
To what extent does the decision process differ for children who are suspected of being physically/emotionally abused or neglected? (Are these children more likely to get services in borderline cases?)
What happens when team members are unable to reach consensus?
What attitudes of participants influence the decisions made about diagnostic assessment?

Costs

How much does the decision-making process cost?

- Break down by personnel costs for meeting time, materials used at meeting, etc.

STAGE 2: DIAGNOSIS/ENTRY

Definitions

What is the district's objective for diagnostic assessment (e.g., to pick up kids with any problems, to pick up kids with specific kinds of problems, etc.)?
Is the diagnostic assessment of a child delimited by a specific reason for referral?

Timing and Setting

When does diagnostic assessment occur?
Is the assessment periodic or continuous?
Is the assessment always completed on an individual basis?
Where is the diagnostic assessment conducted?
What is the average amount of time per child for the diagnostic assessment?

- Break time down by area assessed.

Participants

What proportion of children referred for diagnostic assessment actually are assessed?
To what extent are parents involved in the diagnostic assessment?
What feedback is given to parents on results of diagnostic assessment, and when?
How does the diagnostic assessment process differ for mildly vs. severely handicapped children?

Table 1 - continued

Personnel

What professionals participate in the diagnostic assessment, and what is the role/training of each?
To what extent is there a relationship between referral reason and personnel involved in the assessment?
To what extent is there interagency collaboration in assessment personnel?
To what extent do the attitudes of assessment personnel seem to influence assessment results?
How satisfied are people with the tools/procedures used?

Content

What developmental areas are assessed?
What tools/procedures are used for diagnostic assessment in each area assessed?
Are the same tools/procedures used for all children?
Who decides what tools/procedures are used?
When are alternative tools/procedures used?
Are modifications made for children of different ethnic/cultural/racial backgrounds? What are they?
Is placement in a special education service part of the diagnostic assessment process?
How technically adequate are the tools/procedures used for diagnostic assessment?

Costs

How much does the diagnostic assessment cost?

- Break down by personnel costs, materials costs, etc.

DECISION 2: ASSESSMENT TO PLACEMENT

Definitions

What is the district's definition of an early childhood special education placement?

Timing and Setting

When is the placement (i.e., qualifies for service) and/or category decision made?
Who makes the placement/category decision?

- If team makes decision, see "Team Meeting" questions.

Are any children placed without a diagnostic assessment?
What is the average decision-making time per child?

Participants

To what extent do parents participate in the decision-making process?
What are the characteristics (age, sex, SES, race, parental occupation, test scores) of children who are placed vs. children who are not placed in special education services.
What proportion of children who are assessed are placed in special education?
Are there children who meet special education criteria but do not get placed? How many (proportion)?
How satisfied are people with the decision-making process?

Content

What information is used to decide that a special education placement is/is not warranted?
What proportion of time is spent discussing screening results, parent comments, classroom performance, extraneous issues, etc.?
Is there a "final authority" for questionable cases (e.g., look at Battell to rule out ADD)?
Are there specific criteria for making placement decisions? What are they?
Are eligibility criteria defined in terms of specific tools used for assessment?
To what extent and when are specific criteria ignored?
Are there implicit policies that guide labeling decisions (e.g., when there is doubt, use speech/languge category)?
How is a differentiation made between "areas of need" and "handicapping condition"?
Does the decision-making process differ for borderline cases?
Does the decision-making process differ for mild vs. severe cases?
If services are denied, are any recommendations given to parents?
To what extent do transition/coordination issues affect decisions (e.g., elementary school principal is not helpful if child has problems -- keep in early childhood program)?
For programs that are extended assessments, to what extent does the decision made after assessment differ from the decision that would have been made after one day or one week?
To what extent do labeling issues affect decisions (how is label selected for child with multiple problems)?

Team Meeting

How many people attend the team meeting?
What areas of expertise do the people represent?
To what extent and when are nonprofessional and nonschool staff (parents, physicians, daycare teachers) included in the meeting?
How often are administrative personnel (preschool coordinators, principals) included?
What is the seating arrangement, and does it foster equal participation by all members?
Is a leadership role assigned to a particular staff member?
Does any member(s) dominate the meeting?
To what extent do parents and other nonschool individuals participate?

Table 1 - continued

How many cases are discussed at the meeting?
How many minutes are spent discussing the average case, and what is the range of times?
What factors influence the duration of the decision-making process for each case?
To what extent is there time pressure on decision-making?
Are recommendations made for cases other than a placement decision? If so, what?
To what extent is there a standard format for discussing cases? What is it?
To what extent does the decision process differ for children who are suspected of being physically/emotionally abused or neglected? (Are these children more likely to get services in borderline cases?)
What happens when team members are unable to reach consensus?
What attitudes of participants influence the decisions made about placement?

Costs

How much does the decision-making process cost?

- Break down by personnel costs for meeting time, materials used at meeting, etc.

STAGE 3: INTERVENTION

Definitions

What is the district's objective(s) for its early childhood special education program?
What is the teacher's objective(s) for the intervention program?
What are the basic components of the program?

Timing and Setting

When does intervention occur (e.g., half days, all year, etc.)?
Where does intervention occur?
Who decided where and when intervention would occur? What factors influenced decisions?

Participants

How many students in the class; how many teachers/aides; what is the ratio?
What is the age range of students?
Is class make-up determined by age, disability, severity, etc.?
How often does home-school communication take palce, and in what form?
How are parents involved in the intervention program of their children?
What are the parent's attitudes concerning the effectiveness/appropriateness of their children's intervention programs? Do their perceptoins of the child's progress agree with the teacher's?

Personnel

How many staff members are in the classroom and what are their roles?
How are aides and volunteers used?
To what extent are professionals involved in intervention with the children, how much time, and where does it take place?
How are decisions made about staff utilization?
What are teacher attitudes about the assessment information they receive about a child (i.e., is it helpful?)?
Does the staff think its program's budget is adequate for them to accomplish what they want with the intervention?

Content

How much time is spent teaching in each of the major content areas: self-help, social-emotional, language, visual-motor, cognitive?
How much individual or group instruction, and self-directed time takes place? Is there any differentiation based on mild vs. severe? Which is emphasized?
How is the focus of each child's intervention decided upon? If a child qualifies in one area (e.g., speech), can he/she be served (have objectives for) anything else ?
What kinds of systems level or intangible factors influence the intervention process (e.g., a school requires a teacher to make an improvement every three years, so the teacher decides to get parents more involved)?
Who participates in writing IEP? How much parent input? How are various sources of data used in planning (e.g., assessment scores, observation, etc.)?
To what extent is instruction individualized in the classroom? What evidence is there for this?
What curricula are used, in any? Are they appropriate?
How congruent are the interventions with the diagnostic assessment data?
What is the availability of materials? What is the program's budget?
How much mainstreaming takes place? How are mainstreaming decisions made?
What are the classroom's grouping practices based on?
How often are data collected to evaluate progress, and by whom? What kinds of data are collected?
Who decides whether progress is being made? What methods are used to decide?
How are interventions changed, if at all? How often are IEPs updated to reflect progress?
How much time is spent, relative to intervention, for progress monitoring?

Cost

Does the district have an estimate of what the costs are for intervention for a typical handicapped child?

Table 1 - continued

DECISION 3: INTERVENTION TO EXIT

Definitions

Does the district have specific criteria for deciding when intervention is no longer needed (i.e., exit criteria)?
Does the district have exit goals for children?

Timing and Setting

When are exit decisions made?
When do children typically exit the program (at kindergarten, mid-year, after one-year, etc.)?
Who makes the exit decision?

- If team mades decision, see "Team Meeting" questions.

What is the average amount of time per child spent in making exit decisions?

Participants

What role do parents play in the decision to end intervention?
What are the parents' attitudes about the exit decision process?
What are the characteristics (age, sex, SES, race, parental occupation, etc.) of children who are exited?
Do exit decisions vary with child characteristics (e.g., handicap, age, sex, ethnicity, appearance)?
What are teachers' and others' attitudes about exit decisions?

Content

What are the exit criteria used in decision-making?
What is the procedure for deciding when a child should be exited (formal/informal, tests administered, teacher recommendation, etc.)?
Where do children go when they exit; who decides where; and on what basis are decisions made (program availability, ability to pay, caseloads, child characteristics, etc.)?

Team Meeting

How many people attend the team meeting?
What areas of expertise do the people represent?
To what extent and when are nonprofessional and nonschool staff (parents, physicians, daycare teachers) included in the meeting?
How often are administrative personnel (preschool coordinators, principals) included?
What is the seating arrangement, and does it foster equal participation by all members?
Is a leadership role assigned to a particular staff member?
Does any member(s) dominate the meeting?
To what extent do parents and other nonschool individuals participate?
How many cases are discussed at the meeting?
How many minutes are spent discussing the average case, and what is the range of times?
What factors influence the duration of the decision-making process for each case?

To what extent is there time pressure on decision-making?
Are recommendations made for cases other than a exit decision? If so, what?
To what extent is there a standard format for discussing cases? What is it?
To what extent does the decision process differ for children who are suspected of being physically/emotionally abused or neglected? (Are these children more likely to get services in borderline cases?)
What happens when team members are unable to reach consensus?
What attitudes of participants influence the decisions made about exit?

Costs

How much does the decision-making process cost?

- Break down by personnel costs for meeting time, materials used at meeting, etc.

STAGE 4: FOLLOW-UP

Definitions

How does the district define "follow-up"?
Does a formal follow-up procedure exist?

Timing and Setting

When does follow-up program participants occur?
Who is responsible for follow-up?

Participants

Do program "graduates" continue to need and receive support services? If yes, what kind and from where?
What are the characteristics of children in kindergarten or two years after leaving the early childhood program (proportion receiving special education, academic performance, etc.)?
What happens if a child is not successful in a new classroom/program?
On the average, how long do exited children go without special education services?
To what extent are parents involved in follow-up procedures?

Content

What follow-up procedures are used?
Who obtains or receives follow-up information?
Do those people responsible for exiting a child receive later information about how the child is performing? If so, how is the information used?
Do new programs receive/request information about the child's past performance? If yes, what information goes along with the child and who receives it?
To what extent is there contact between the old and new programs?
Does the program assess parents' satisfaction or attitude toward the child's progress, performance, or subsequent placement?

Table 2

Guiding Questions for Description of Programs

Community Characteristics

- Location in state
- General SES characteristics
- Size of district, with breakdown by age
- Influence of community characteristics on program as perceived by administrators, teachers, parents, observer

Physical Setting

- Characteristics of building(s) and rooms in which located
- Proximity to other special education and regular education programs
- Influence of physical setting on program as perceived by administrators, teachers, parents, observer

Organization and Staff

- Lines of authority
- Amount of structure
- Interaction styles
- Key leaders
- Characteristics of staff (number, training, qualifications, interest, etc.)
- Advocates and adversaries
- Influence of organization and staff on program as perceived by administrators, teachers, parents, observers

History/Rationale/Philosophy

- How and when started
- Why exists
- Desired outcomes
- Program goals
- Who should be served

Other Influences

- Recent or anticipated changes in program
- Inconsistencies in program (variability among staff, seasonal changes in participants, etc.)
- Political movements
- State department influences

Monetary

- Money available and sources
- Funding formula
- Distribution of money (staff, supplies, equipment, travel, maintenance, etc.)

all data from the rural site were collected during a three-month period in the spring.

Data collection procedures included: (a) observations of meetings, classroom activities, screening and assessment procedures, (b) extensive interviews with various staff and administrative personnel, (c) file searches, and (d) parent surveys. Although specific data collection procedures varied as a function of differences in the programs, the same research questions were asked in all sites. Detailed information describing preschool screening, diagnostic assessment procedures, the instructional programs, program exit procedures, and follow-up data on student participants was gathered for each site.

Overview of Chapters 2-5

The remaining chapters in this report present the results of the four case studies of the assessment and decision making approaches in four districts. Within each program report, findings are reported for the major stages and associated decisions in the assessment and decision-making process. As might be expected, the amount of information that could be collected within a particular stage varied with the school district.

For policy analysis purposes, the findings across school districts were integrated for each stage (with exit and follow-up combined). These integrations and implications are reported in Research Reports 11 to 14.

Final Word of Introduction

The openness and willingness to participate in research shown by the early childhood special education programs is a finding in itself. In detailed surveys of programs, we received surveys from nearly 80% of those contacted. Program coordinators were willing to spend considerable time being interviewed. Teachers, similarly, were open to observations and interviews. The four programs described in this report showed extreme openness to the research process. They all were committed to the children they served and were looking for information that could help ensure that the best practice possible was being implemented. It is hoped that through the descriptions provided here, as well as through the integrative reports and policy analyses presented in Reports 11 to 14, all programs will find information that will help. At the most basic level, the reports will help programs see how others approach the entire assessment and decision-making process. At another level, the reports can help programs think about the kinds of questions that need to be asked and issues that need to be raised when considering the process for identifying young children as handicapped and providing special education services to them before they reach school age.

Chapter 2: Program A

Patrick J. O'Sullivan

Program A is an early childhood special education program that serves approximately 250 children from diverse cultural and socioeconomic backgrounds in an urban setting. This program has evolved over a relatively long period of time (since 1968). An overview of the relationship among screening, assessment, intervention, and exit for Program A is provided in Figure A-1.

Program Description

Community Characteristics

Program A is located in a large urban school district (District A) in Minnesota. Compared to other Minnesota school districts, District A falls at the 42nd percentile for median family income, and at the 12th percentile in median age of residents (Bureau of the Census, 1982). About 38% of the residents in the school district's boundaries are minorities, placing the city above the 99th percentile within the state (Minnesota Department of Education, 1984a; School District Information, 1985). According to the school district, about 45% of special education preschoolers are minorities (1985).

Program A students are from diverse cultural and socioeconomic backgrounds, and many students come from low-income and/or single-parent families. The average number of handicapped preschoolers in Program A over the school year is about 250. About 90% of these children attend School 1, and the remaining severely handicapped preschoolers attend School 2 (physical handicaps), School 3 (hearing-impaired), and School 4 (autism). Of the handicapped children between birth and five years of age, most (61%) are four years old; only 10% are in the birth to three year old range.

Physical Setting

Both parents and school staff gave high ratings to the school building and facilities. Teachers said the physical characteristics of the school create a very positive atmosphere, which compares favorably to other settings they have seen. Results of a survey indicated that 97% of parents were satisfied with the school building, although fewer parents (87%) were satisfied with the school's location.

The school in which Program A is located is in a lower-middle class neighborhood. The program is housed in a U-shaped building constructed in 1918. Although the bricks are dingy appearing and paint peels from the front door and entryway, the building interior is clean, colorful, and well lit. Administrative offices and the teacher lounge are located in the front of the building, with 13 classrooms aligned along the two long corridors. The classrooms have their own bathrooms, which cuts down on distractions from hallway traffic. An assessment room has two small adjoining rooms, so children

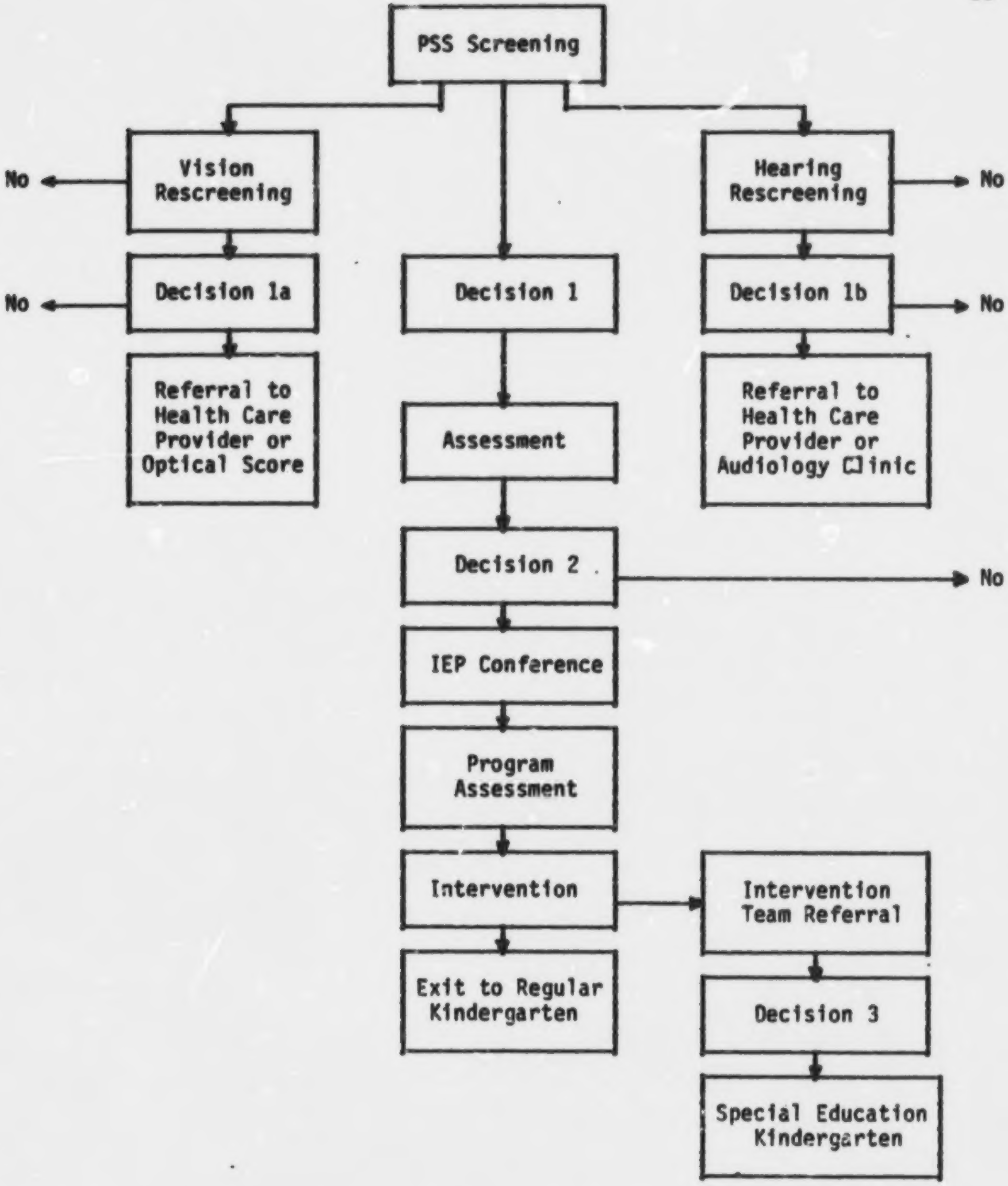
PSS Screening
Vision Rescreening
No
Hearing Rescreening
No
Decision 1a
No
Decision 1
Decision 1b
No
Referral to Health Care Provider or Optical Score
Assessment
Referral to Health Care Provider or Audiology Clinic
Decision 2
No
IEP Conference
Program Assessment
Intervention
Intervention Team Referral
Exit to Regular Kindergarten
Decision 3
Special Education Kindergarten

Figure A-1. Major stages and decision points in Program A's early special education assessment and decision-making process.

can be tested individually with minimal disruption to on-going instruction. The school also has an open outdoor playground, an enclosed but open-air playground with play equipment, and an indoor gymnasium.

Organization and Staff

At the top of the administrative hierarchy is the Superintendent of Schools, then the Director of Special Education Services, followed by an Administrator of Special Programs, and finally the Director of Program A. The professional staff of Program A function on an equal footing as members of assessment/intervention teams. Staff members are allowed considerable discretion in determining what they do and with whom they work, according to teachers. Each teacher supervises the aide assigned to the classroom. Other professionals team with several classroom teachers for assessment and consultation during intervention. Teachers function as case managers for children in their classroom. Classrooms are organized by intregrating handicapping conditions, so that children with different handicapping conditions are placed in each classroom. The two hearing-impaired classrooms are the exception, where children are grouped according to the severity of their hearing loss.

Program A interweaves its functions with other community agencies serving handicapped preschoolers. The district Interagency Early Learning Committee (IELC) was formed to promote interagency collaboration, and reduce gaps and duplications in services. The Program Director expects that IELC will lead to more efficient use of available resources. Beginnings of such collaboration are evidenced by the use of the Program A screening tool by several other agencies.

The Program Director used adjectives such as "excellent" and "superb" to describe the school's staff. She reported that all staff members hold licenses in their specialty areas, and that little staff turnover has occurred in the past 5 to 7 years. In a sample of 18 staff members attending a January staff meeting, the median length of post-academic experience was 10 years (range = 0.5 - 31.5 years). Use of a multidisciplinary team approach to assessment and intervention encourages frequent interaction among the staff and collaborative problem-solving efforts, according to teachers. The staff meets as a whole group twice each month for 60-minute sessions. Every two weeks teachers, social workers, and speech/language clinicians hold one hour peer group meetings for collaborative problem solving and mutual support.

In terms of full-time equivalent positions, the staff includes: 13 teachers (3 teachers of the hearing-impaired), 13 aides, 4.5 speech/language clinicians, 4 social workers, 1 psychologist, 1.5 occupational therapists, 1 school nurse, 2 preschool screening nurses, 2.5 clerical workers, and the Program Director. Other special education personnel from the district consult with Program A staff when the need arises (e.g., physical therapists from School 2).

For a number of reasons, Program A teachers reported feeling somewhat isolated from the community and the rest of the school district. They wonder how others, particularly parents, view the program, but reported that feedback from parents has generally been quite favorable. However, since students only attend the program for one school year, there is little time to establish enduring relationships with parents. Teachers also said they feel removed from the rest of the school district, perhaps partly because the program is physically and administratively distinct from the K-12 system. They want to know more about programs and services offered in elementary schools, and would like to inform other educators about their program. Teachers also wonder if the community considers preschool education to be important, compared to the teaching of basic skills in elementary school.

In a survey of the parents of children attending Program A, high ratings of the program were obtained (see Appendix A-1 for a copy of the survey). From 94% to 100% of the parents reported being satisfied with the school staff, services, and the overall program. Of the other areas covered by the survey, bus services received the lowest ratings of satisfaction (76%) by parents.

History/Rationale/Philosophy

Program A began in 1968 as a regional hearing-impaired program following the 1964-65 rubella epidemic. With the passage of P.L. 94-142 in 1975, the program expanded to include services for all moderately to severely handicapped preschoolers. The rationale for special education services to preschoolers developed from a broad-based social and political movement that culminated in federal and state legislation. It specifies everything from purposes and goals to pupil-teacher ratios and funding formulae (e.g., Minnesota Department of Education, 1984b). Federal law requires State Education Agencies (SEAs) to find and identify all handicapped children, and provide them with a free and appropriate education in the least restrictive environment by designing individual education programs (IEPs) tailored to the needs and characteristics of each child.

Program A assumes that special education provided to handicapped preschoolers is more valuable than no special education services (School District Information[1], 1984). Brochures (1985) describing the program emphasize treatment of the "whole" or "total" child, taking into consideration the child's strengths as well as weaknesses, and including the family in the assessment/treatment process. The Program Director, teachers, and the brochure emphasize the importance of play activities as a treatment avenue for maximizing the development of handicapped children. The Program Director also believes that a multicategorical classroom grouping of children (several categories within a single classroom) and a professional team approach to special education lead to increased social learning opportunities for children, and more comprehensive assessment/treatment procedures.

Other Influences

A variety of recent, periodic, and anticipated events influence the program. A few of the more important events producing changes in the program are presented here.

First, a primary concern of the Program Director and staff is extension of special education services to include three year olds beginning in Fall 1986.

Next year's budget will include funds for an additional assessment team and case managers needed to identify handicapped three year olds. A staff development grant will be sought to facilitate assessment next fall.

Second, at a spring staff meeting, the Program Director informed the staff that the program will move to another building in September 1986 because of anticipated enrollment increases that will require use of the building as an elementary school. A district plan concerning use of buildings calls for Program A to be housed in a former junior high school building for at least the next three years.

A third event was a schedule change. In Fall 1985, preschool intervention classes changed from a four-day to a five-day per week schedule. The schedule change intensified the intervention experience, but also left the staff with less time for ancillary duties (e.g., paperwork, meetings, parent education classes). A number of changes in assessment procedures occurred during the school year. The changes that make up this fourth area include:

- Since Fall 1985, the "motor" area of assessment has been replaced with a more general "readiness" area.
- The teacher-developed "Quadrant" rating system for assessing social-emotional development was replaced by the Personal-Social scale of the Battelle and a behavior checklist developed by one of the school psychologists.
- The Battelle Developmental Inventory replaced the Brigance for assessing readiness skills.
- Changing assessment from a four-day to a five-day schedule was considered.

A fifth event that occurred was that one full-time screening position was eliminated in the fall of 1985 because of budget constraints. A procedural factor that influenced the program relates to scheduling assessments. Each spring, assessment teams begin identifying handicapped students for the following year by assessing DAC children. Children who fail preschool screening are assessed in the summer. The assessment team continues to identify handicapped children for the current school year until February. As a result, program enrollment gradually increases until February, and then remains relatively stable until the end of the school year. As of the 1984-85 school year, district policy does not allow students to be retained in the program.

Funding

All Program A services are offered at no cost to parents as federal law dictates. The program is supported by federal, state, and local education funds. The percentages of revenue from federal, state, and local sources for the entire district in 1982-83 are shown in Table A-1. A shift occurred between the two years, with state funds accounting for a greater percentage in 1983-84 than in 1982-83.

Table A-1

Percentages of Revenue for District A

Year	Federal	State	Local
1982-83	7	19	74
1983-84	7	32	61

Table A-2

1984-85 Expenditures in Program A

Budget Area	1984-85 Expenditures
Teacher Salary	$ 453,405
Social Worker Salary	97,500
Administration/Clerical Salary	78,950
Nurse and Teacher Aide Salary	73,350
Supplies and Materials	15,586
Total	$ 718,791

In 1983-84, the budget for Program A staff salaries (excluding administration) was $810,210. Thirty-one percent of this amount came from P.L. 94-142 (federal) funds.

Complete budget information could not be obtained because the district's centralized accounting system combines some budget areas across school programs and buildings. Hence, no breakdown of revenue or expenditures at Program A was available for transportation, building maintenance, support services, and special education administration areas. Available information was primarily related to staff salaries. Expenditures for 1984-85 in those available areas from state/local funding sources are in Table A-2.

In addition, 1984-85 expenditures from federal (P.L. 94-142) sources amounted to $327,013, covering salaries for 9.2 teachers and incentive Grant funds. Together, the expenditures from these federal and state/local sources totaled $1,045,804.

Screening-Referral Procedures and Decisions

Background

Preschool screening in District A is part of the statewide Preschool Screening (PSS) program for 3½ to 5-year-old children administered by the state education department. In District A, its purpose is to "detect common problems before they become serious," and provide parents with "up-to-date information about their child's development" (School District Information[1], 1985). Preschool screening is differentiated from assessment by its procedures, tools, and personnel. Thus, developmental screening is defined as administration of a locally-developed screening tool (LST) by nurses hired specifically to conduct screening. Children who fail screening with the LST are referred for developmental assessment at School 1. Administration of a screening tool (e.g., LST, DDST, DIAL) by another agency is also considered a screening procedure, and may lead to a direct referral for developmental assessment at School 1, bypassing PSS. Other agencies that screen District A preschoolers include a children's medical center, the local public health department, a child guidance clinic, the county social services, DACs, and several private agencies.

Preschool screening also serves as a gateway to special education assessment by the multidisciplinary team at School 1. According to preschool screening nurses, there has been an effort during the past year to have all children screened before they are referred for further assessment at School 1. Developmental assessment for eligibility is conducted by a team of professionals at School 1, who administer a variety of tests and informal procedures during a four half-day classroom assessment period. Vision and physical health assessments are conduted by nonschool professionals (e.g., MDs), and generally do not lead to eligibility for special education services. Children in the hearing-impaired program in School 1 have severe hearing losses that are detected before age 3½ years. Hearing assessment to determine eligibility for this hearing-impaired program is conducted by a special assessment team at School 1, including a teacher of the hearing impaired, teacher aide, audiologist, social worker, and speech/language clinician. Of course, hearing assessment can be conducted by other agencies and professionals, but eligibility for the School 1 program is determined by the School 1 assessment team.

All children are screened in five required areas: vision, hearing, school readiness (development), height/weight, and health history review (when information from parents is available). Children eligible for medical assistance (MA) also are screened in four optional areas: dental, nutrition, physical inspection, and laboratory tests (urinalysis, blood tests). Children may be screened only once, and the screening nurses bring a list of children screened the previous year by PSS and the city health department to help ensure that screening is not duplicated. Also, children are not screened in areas that have been checked recently by a health care provider. The exception is MA-eligible children, who may be re-screened even if seen recently by another health care provider. Screening is offered at no cost to parents, and the school district is reimbursed by the state ($15.60 per child for required components).

Time and Setting

PSS screening takes place continuously between September and May each year. Table A-3 is a summary of the number of children screened at open sites, daycares, and through direct referrals by other agencies during each of the past three years. Screening at more than 40 "open sites," usually city recreation centers, takes place in April and May. Most children (53% in 1984-85) are screened at day care programs. Screening appointments are scheduled in advance in 30-minute time blocks. When parents are not present, which is usually the case at day care programs, screening takes about 20 to 30 minutes for required components, according to screening nurses. When parents are present, the nurses spend additional time discussing screening results with them. About 45 minutes is taken to complete both the required and optional components of screening MA-eligible children.

Participants

Several procedures are used to notify the public about when and where preschool screening takes place, including flyers sent home via school-age children, newspapers articles, TV/radio announcements, and notification of service agencies and day care programs. Parents having their children screened were asked how they found out about preschool screening, and over the past two years more than half the parents (62%-64%) cited day care centers as a notification source. Flyers sent home from school were the next most often cited means of notification reported by parents (15%-19%).

All children from 3½ to 5 years of age who are residents of District A are eligible for preschool screening at no cost to parents. The screening process is the same regardless of the child's age, although the nurses said they alter their approach or method of administration for children who are difficult to screen. Severely handicapped children do not attend screening, according to nurses, since they already have been identified as handicapped.

Table A-3

Screening Totals Across the Three Most Recent Years for Open Site, Daycare, and Direct Referral Screenings

	1982-83	1983-84	1984-85
Open Sites	968	807	794
Day Cares/Family Day Cares	957	1,117	1,156
Direct Referrals	141	99	221
Total Screened	2,066	2,023	2,171

Table A-4

Ethnic Distributions of Children Screened in 1984-85 at Open Sites, Daycares, and Among All Children Screened

Ethnic Group	Open Site	Day Care	Total
Native American	23 (3%)	37 (3%)	60 (3%)
Asian	19 (2%)	49 (4%)	68 (3%)
Black	71 (9%)	161 (14%)	232 (12%)
Spanish	12 (2%)	15 (1%)	27 (1%)
Other	669 (84%)	894 (77%)	1,563 (80%)

Each year about 60% of the eligible children in District A are screened, based on the number of children screened each year and kindergarten class sizes. Data are unavailable about the characteristics of children who are not screened. The nurses reported that children who are missed may include those from Native American families who move to and from reservations, some first-time mothers, some children in private day care homes, and some "needy/high-risk" families. In 1984-85, 9.4% of all children screened came from families receiving medical assistance. Overall, 19.6% of the children screened in 1984-85 belonged to minority groups. Table A-4 is a summary of data on the ethnic distribution of children screened in 1984-85.

Role of Parents

Parents must sign a consent form to allow screening. They can observe the screening process, and sometimes help the nurses when a child has difficulty understanding or following instructions. The nurses said parents of day care children typically are not present during screening, since they are often working or attending school. Day care personnel are contacted by the nurses for information they have about the health and development of children they supervise.

Because of time constraints created by the large numbers of children screened by the nurses, less time is available for talking with parents about health and developmental education issues than in past years. As a result, the nurses said they try to have a lot of brochures and printed materials available for parents to take home.

Personnel

Public Health Nurses hired specifically to conduct preschool screening administer all screening components. Each year the nurses attend inservice training sessions run by the State Department of Health. The nurses reported feeling satisfied with the screening tools and procedures they use.

Content

General developmental or school readiness skills are assessed using the LST, which was standardized and normed on city A children. The HOTV chart is used for screening visual acuity, and eye muscle imbalances are detected with the Hischberg-Light Dot and cross-over-movement tests. Pure tone audiometry is used to screen hearing. Parents can request that specific screening components by omitted if they desire. If for example, a child had a recent vision exam, the vision component may be omitted. As mentioned previously, the optional screening components are provided to MA-eligible children.

Referral Decisions

The screening nurses, along with parents, decide whether children should be referred for more in-depth diagnostic assessment. Children who fail hearing screening are re-screened within two weeks by the PSS nurses. During hearing rescreenings, vision is also rescreened by one of the nurses. The nurses estimated that 5% to 15% of the children re-screened in hearing are referred for further assessment. Children who fail the vision component are also re-screened immediately after the original vision screening by simply repeating the procedure.

Some children who pass screening still may be referred for further assessment if the parent has "real big concerns" about the child's health or development. Speech and social development are the areas where parent input, information from day care personnel, and qualitative aspects of the screening process are given the most weight by the nurses, especially in cases where children fall in the "borderline" region between passing and failing.

Age-normed cutoff scores on the LST are the criteria used to decide whether to refer children in the developmental area. In hearing, children are referred if a hearing loss of 25 dB at 500 Hz, 20 dB at 1000 Hz or 2000 Hz, or 25 dB at 4000 Hz is detected in either ear. Visual acuity worse than 20/40 in either eye, or indication of eye muscle imbalance is the criterion for referral in vision. Evidence of inappropriate health care or presence of a health-related problem or abnormality constitute referral criteria for health history and optional screening components.

Referral Agencies

Referrals in the developmental area are sent to School 1 for assessment by the multidisciplinary assessment team. When children are too old for the Longfellow program (i.e., almost 5 years old), the nurses tell the parents to contact the school the child will attend next year. Referrals in the hearing area (following re-screening) may be to the family's health care provider, or to the University's Audiology Clinic, which offers free first-time visits. Vision referrals go to the family health care provider or a retail optical store. Referrals in health history and optional screening areas typically are sent to the family health care provider. A summary of the number of children screened and referred in each screening area is presented in Table A-5.

In some cases the nurses may "suggest" that a child be seen by another professional such as a neurologist, particularly when parents want more information about their child's health or developmental status. Such "suggestions" are not considered formal referrals, since no reimbursement agreements exist for them.

Follow-Up

The nurses follow up on referral recommendations by sending a postcard reminder one month after the referral was made, and telephoning parents if

Table A-5

Number of Children Screened, Referred, and the Percentage of Children Referred for Each Screening Area in 1984-85

Screening Area	Number Screened	Number Referred	Percentage Referred
Developmental	1,944	221	11.4
Vision	1,798	79	7.9
Hearing	1,799	45	2.5
Health History	403	111	27.5
Dental	166	112	67.5
Nutrition	40	3	7.5
Laboratory	22	4	16.2
Physical	23	9	39.1

necessary. The screening nurses try to complete follow-up efforts within 60 days of the referral for further assessment. Parents sometimes do not follow through with recommendations for further assessment because they change their minds, or sometimes because they move and cannot be reached. Referrals for assessment at School 1 are followed up by the school secretary, who sends out three letters to parents, and also tries to telephone parents to schedule assessment.

Other Influences

An important influence on screening, according to nurses, was the 50% budget cut two years ago, and the additional 50% budget cut scheduled for next year. As a consequence of the past budget cut, the nurses must screen more children, which leaves less time for discussion with parents and for ancillary duties (e.g., facilitating referrals). The nurses expressed concern about the potential impact of next year's budget cut on screening services.

Because children are screened at many different sites, the facilities and quality of the atmosphere for screening vary with each location; these sometimes affect the screening process. For example, sometimes physical inspections are complicated by frigid temperatures, or hearing screening by a noisy environment.

Diagnosis to Entry

Assessment in Program A involves a two-step process. The first step is referred to here as "eligibility assessment," and involves procedures that lead to a decision about whether a child is eligible for entry into the program (i.e., is handicapped or not). Typically, children are deemed eligible for Program A when a handicapping condition is diagnosed by the multidisciplinary assessment team following a four half-day classroom assessment (see "Exceptional Cases" below for alternative entry procedures). The purpose of eligibility assessment is to identify handicapped children using criteria developed by the district and state education department. Children with handicaps in readiness, speech/language, social-emotional, and/or cognitive skill areas are eligibile for programming. Following the assessment period, the assessment team meets to discuss program eligibility decisions and placement options for individual children (see "Team Meeting" summary in Appendix A-2). Then, IEP conferences are scheduled to inform parents of the team's findings and recommendations. Team meetings, paper work, and IEP conferences are held during a three-day period following the four-day assessment period.

The second step in assessment, denoted here as "program assessment," occurs during the six-week period following eligibility assessment, with children deemed eligibile for the program. In this phase, more in-depth assessment procedures are conducted, building upon findings of the eligibility assessment, to provide additional information that will be used to make decisions about the specific amount and type of intervention services to be provided. Thus, program assessment is directed toward the subset of children found to be handicapped during eligibility assessment (roughly 60% of those undergoing eligibility assessment). Also, those children for whom an eligibility decision was postponed by the assessment team pending further assessment (about 15% of those assessed for eligibility) undergo an additional six-week assessment. Program assessment is conducted by the classroom "intervention team," while eligibility assessment is conducted by an "assessment team." This section is a description of the eligibility assessment process. Note that assessment procedures changed considerably in 1985-86, as the program implemented more objective and standardized methods. Program assessment is described within the Intervention section.

Time and Setting

Eligibility assessments are conducted throughout the year. However, about half of the assessments were conducted during three-week summer sessions and in September, when most of the handicapped children were identified for the school year. In the 1986 summer session, five assessment teams assessed about 120 children in morning and afternoon sessions during three weeks in June. Assessment in September was a massive operation, where about 200 children were assessed in seven assessment classrooms over a three-week period. Then, two assessment teams completed morning and afternoon assessment from October until mid-March. In March and April the two assessment teams traveled to community sites (e.g., DACs, day cares, hospitals) to conduct assessments. This year, about 120 children were assessed at community sites.

At the Program A site, children attend half-day assessment sessions for four consecutive week days. Team meetings are scheduled on the fifth day of each assessment session to determine program eligibility and programming options. Six children participated in each half-day classroom assessment session during the school year, and five children participated during the summer sessions. Estimates of the average amount of time (in hours) per child that each team member spends assessing children directly and indirectly (e.g., paper work, consulting with team members) are presented in Table A-6. Estimates represent the average or median time reported by team members. Total time across team members was almost 11 hours; about 7 hours of that time involved indirect contact. Team meeting and IEP meeting time are not included in the estimates in Table A-6.

Participants

Children in District A who are 4 years old by September are eligble for special education services at Program A. Many of the children assessed at Program A were referred from preschool screening (PSS). During the past year, an effort was made to have all referred children go through preschool screening before being assessed. In 1984-85, 221 children were referred for assessment after failing the developmental component of PSS. Table A-7 is a summary of data on the number of referred children who were assessed and not assessed at Program A over the past two years. In 1984-85, 320 out of 518 referred children (62%) were assessed, and in 1985-86, 372 out of 581 referred children (64%) were assessed. Most of the remaining children were assessed the following summer or fall.

Table A-6

Number of Hours That Team Members Spend Per Child in Direct and Indirect Contact During Eligibility Assessment

Team Member	Direct Contact	Indirect Contact	Total
Teacher	1.67	1.67	3.34
Aide	1.67	.67	2.34
Speech Clinician	.50	1.50	2.00
Psychologist	.75	1.00	1.75
Social Worker	0.00	2.00	2.00
Total	4.59	6.84	11.43

Table A-7

Number and Percentage of Referred Children Assessed and Not Assessed at Program A From Spring 1984 to Spring 1985, and Spring 1985 to Spring 1986

	Number of Children	
Category	1984-85	1985-86
Referrals Assessed	320 (61.8)	372 (64.0)
Direct Referrals (e.g., DACs)	55 (10.6)	66 (11.4)
Retained (Hearing-Impaired)	31 (6.0)	13 (2.2)
Inappropriate Referrals	2 (0.4)	5 (0.9)
Parent Moved, Uninterested, etc.	110 (21.2)	125 (21.5)
Total	518 (100.0)	581 (100.0)

Table A-8 is a summary of data provided by Program A on the number of referred children who entered and did not enter the program in 1984-85 and 1985-86. For the past two years, 52% to 54% of referred children were programmed. Of the children actually considered for the program (those who did not move, etc.), the percentages of children admitted were 66% and 69% for the past two years. And finally, just considering children who were assessed at School 1 (excluding direct referrals, retained children), the percentages of children admitted to the program were 58% and 62% for 1984-85 and 1985-86, respectively.

A breakdown of the number of children diagnosed as having various handicapping conditions during 1984-85 is presented in Table A-9. The data in this table reflect a duplicated child count. In other words, children who met criteria for mulitple handicapping conditins were counted more than once. Under this counting system, the most frequently occurring handicapping condition was social-emotional, followed by speech/language. The diagnosis of other handicapping conditions was considerably less frequent. The "mental retardation label" was not used at all.

Parents first become involved in the diagnostic process when Program A clerical staff try to schedule referred children for assessment. Contact efforts include three letters and an attempt to reach parents by telephone. Since spring 1986, the clerical staff also has sent health and social history forms to parents to fill out and bring to the assessment session. The decision to send these forms home to parents was made to reduce the time involved in completing forms on the first day of eligibility assessment. In the past two years, 21% of the parents of referred children could not be contacted or were not interested in having their children assessed (see Table A-8). Parents who agree to have their children assessed were interviewed by a social worker and school nurse on the first day of the assessment period. Social workers and/or the school nurse obtained health and family histories during semi-structured interviews, and sought to gain understanding of the parent's conception of their child. Following assessment, parents attended IEP meetings, where assessment results and program/placement decisions were discussed.

Personnel/Duties

The multidisciplinary assessment team includes an early childhood special education teacher, teacher aide, psychologist, social worker, occupational therapist (OT), speech/language clinician, and school nurse. Teachers and aides supervise individual and small group classroom activities during daily 2 ½ hour sessions over four consecutive days. They also administer parts of standardized tests, observe child behavior, and fill out behavior rating scales. The psychologists and speech clinicians administer standardized and nonstandardized assessment procedures to individual children, and sometimes observe individual children in the classroom.

Speech clinicians assessed only those children referred because of speech concerns or those identified during assessment by an assessment team member as having a suspected handicap in speech/language skills. The involvement of OTs in eligibility assessment declined during this past year. From September

Table A-8

Number and Percentage (in Parentheses) of Referred Children Entering and Not Entering Program A in 1984-85 and 1985-86

	Number of Children			
	1984-85		1985-86	
Total Programmed	270	(52.1)	312	(53.7)
Total Not Programmed	137	(26.4)	138	(23.8)
Parent Uninterested, Moved, etc.	110	(21.2)	125	(21.5)
Other	5	(0.2)	5	(0.1)
Correction	- 4		+ 1	
Total	518	(100.0)	581	(100.0)

Table A-9

Number of Children in Handicapping Categories (Dupliated Count) During 1984-85

Handicapping Category	Number	Percentage[a]
Social-Emotional	158	37.8
Speech/Language	141	33.7
Developmental Delay	46	11.0
Sensory Integration	32	7.6
Physically Handicapped	32	7.6
Hearing Impaired	8	2.0
Visually Impaired	1	0.2
Menally Retarded	0	---

[a] Percentage reflects proportion of total number of labels (n = 418) identified by duplicated count (i.e., children counted more than once if given more than one label).

through December, OTs administered the gross motor subtest of the Brigance Inventory of Early Development as part of assessment in the readiness area. In September, OTs administered the gross motor subtest to all children assessed, but after that, the gross motor subtest was administered by OTs only to those suspected of having motor problems (about 30% of children assessed). Social workers obtain social and family histories from parents, and information from agencies having contact with the child. The school nurse primarily is responsible for providing results of screening and obtaining health information from parents and other agencies. At times, especially during busy periods of assessment, other psychologists in the district assist with assessment in cognitive and social-emotional areas.

Typically, assessment teams met before the assessment session began to discuss assessment needs of particular children, and assign case managers for each child. Case managers were responsible for completing paperwork for individual children, leading IEP meetings with parents, and writing initial IEPs for eligible children. Team members also met informally with each other throughout assessment sessions to talk about particular children or more general issues.

Assessment Tools/Procedures

Readiness. The tools and procedures used to assess the readiness skill area changed during the 1985-86 school year. Table A-10 is a summary of the different procedures and tools used over the school year in readiness and social-emotional areas. In September 1985, informal procedures were used to assess readiness skills, and program eligibility was based on judgment of team members.

From October 1985 until mid-March 1986, the fine motor speech/language, self help, general knowledge, and sometimes the gross motor subtest of the Brigance Inventory of Early Development were used to assess readiness skills. Brigance subtests were administered in sections by the psychologist, teacher, aide, social worker, speech clinician, and OT (see Table A-11). Further breakdown of the Brigance items and sections administered by team members is presented in Appendix A-3, which also includes coding procedures and eligibility criteria in the form of readiness age equivalents. An overall readiness age (RA) score was obtained by determining the median subtest score on the Brigance. Then, a percent delay score was obtained by dividing the difference between chronological age (CA) and RA by CA, and multiplying the result by 100. To simplify matters, a table of cut off scores as a function of CA was used by team members (see Appendix A-3). Children were deemed handicapped and eligible for special education services at Program A if a delay score of 33% or greater was obtained in readiness, or a delay score of 25%-32% in readiness and another area (social-emotional, cognitive, or speech/language) was obtained. Actual decisions about program eligibility took into account delay score errors of measurement, so that children whose delay scores were within two or three points of eligibility criteria were considered potentially eligible for the program, depending on supportive data and clinician judgment.

During assessments at community sites in April and May 1986, and since that time, the Battelle Development Inventory (BDI) has been used to assess

Table A-10

Summary of Assessment Procedures Used for Readiness and Social-Emotional Areas in 1985-86

Readiness		Social-Emotional	
Dates	**Procedures**	**Dates**	**Procedures**
9/85- 10/85	Informal Procedures	9/85- 12/85	Quandrant System
10/85- 3/86	Brigance	1/86- 6/86	Batelle Personel-Social Subtest
4/86- 6/86	Batelle	9/85- 6/86	Parent Interview
1/86- 6/86	Informal Rating Schedules	1/86- 6/86	Informal Rating Schedules

Table A-11

Summary of Assessment Duties for Assessment Team Members During the Time That the Brigance Was Used

Team Member	Readiness	Social-Emotional	Cognitive	Speech
Psychologist	Brigance*	Standardized Peer-* Referenced Observation Behavior Scale	Standard Test* (Kaufman), + Adaptive Behavior	Brigance*
Teacher	Brigance*	Quandrant, Bx Ratings* (BDI Personal-Social)[a]	*	Brigance*
Aide	Brigance*	*	*	*
Social-Worker	Brigance* (Self-Care)	Parent Interview* Records		
Speech Clinician	Brigance*	*	*	Language Subsystem
OT	Brigance* (Gross Motor)	*	*	*

*Indicates use of informal observations by team members

[a] Replaced Quandrant System in January 1986

eligibility in the readiness area, replacing the Brigance. The program director and staff choose the BDI for a variety of reasons, including: (a) improved standardization and availability of norm-referenced standard scores; (b) the choice of administering BDI scales by testing children directly, observing their behavior in the classroom, or by using parent reports of behavior; and (c) staff judgment of the superiority of the BDI in providing instructionally-relevant information during trial administrations of the instrument at Program A in spring 1986. Most of the assessment team members are taking a "wait-and-see" attitude about the validity and efficacy of the BDI, but expressed optimism that the scale should lead to improvement in assessment procedures and outcomes. Assessment teams have tried several ways of dividing BDI administration among team members, and alternative administration methods (i.e., observation, direct testing, parent report) for different BDI domains and items. Table A-12 presents a tentative outline for team administration of the BDI in fall 1986.

Eligibility criteria for readiness using the BDI are based on the overall BDI score, which encompasses five domains: personal-social, cognitive, motor, communication, and adaptive behavior. Children evidencing a 2.0 standard deviation (SD) discrepancy from age expectations in readiness, or a 1.5 SD discrepancy in readiness and the social-emotional area (using the BDI Personal-Social scale) were eligible for the program, if evidence from other sources (e.g., observation) supported the estimate of the child's functioning. Speech/language and cognitive handicaps were determined using other procedures and criteria, as described below.

Speech/Language. For language assessment, the speech clinicians use a district-developed, unnormed procedure that measures expressive language development in four areas: intelligibility, use, complexity, and utterance length (MLR). The purpose of the procedure is to determine program eligibility and the level of language intervention. Measures are based on structured and unstructured language samples, although the speech clinicians seldom have time to obtain the unstructured language sample during eligibility assessment. Unstructured language samples are obtained by assessment teachers, or later by speech clinicians for children placed on direct service. For children determined to be eligible for language services on the basis of the district procedure, the Zimmerman Preschool Language Scale (PLS) must also be administered. Other tests specified by the district (e.g., TACL, ACLC, SICD, Gesell Action-Agent, Hawaii Early Learning Profile) can be administered to support the eligibility decision.

Criteria for program eligibility involve cutoff scores by age in the four areas assessed by the district procedure. For 4-year-old children, these cutoffs for service are:

1. Intelligibility - below 70% intelligible
2. Form - either MLR or Complexity below district cutoffs of 2.5
3. Use - below 60% relevant use

Children who meet two out of the three criteria above are eligible for direct service (Level III) or indirect service (Level II), while those who meet one of

Table A-12

Proposed Batelle Administration Duties
for Assessment Team Members in Fall 1986

Batelle Domain	Assessment Team Member
Personal-Social	Teacher, Psychologist
Adaptive	Social Worker
Motor	Aide, Occupational Therapist
Communication	Teacher
Cognitive	Psychologist, Teacher

the criteria may receive indirect (Level II) "Monitoring" services. Program eligibility also is based on language problems not attributable to cultural/ethnic variations. Special program eligibility criteria for children who speak variations of ethnic English are provided by the school district. Such children must manifest problems that are not directly attributable to ethnic patterns during assessment, observation, and classroom and home environments.

The Photo Articulation Test (PAT) is used to assess speech articulation. When speech clinicians note problems with vocal quality that may be related to nodules on the vocal cords, they suggest that the parent have the child assessed by a physician. A doctor must determine the presence of nodules in order for the child to receive voice therapy in Program A.

Social-Emotional. From September through December 1985, the Quadrant System or "Quadrant" as it is called, was used to assess the social-emotional area. The Quadrant, an unstandardized teacher rating scale, includes teacher ratings of 55 behaviors along two dimensions: the severity of the behavior (4-point scale), and the amount/type of teacher intervention needed to change the child's behavior (6-point scale). At the end of the four-day assessment period, teachers and aides rated the 55 behaviors for each child on each dimension, and placed the results on a graph of 24 squares or quadrants. The graph provided a visual summary of the selected behaviors in terms of their severity and the degree of teacher intervention needed to change behavior.

Quadrant ratings of the severity of behavior problems and the degree of teacher intervention needed to change inappropriate behaviors were used to gauge subjectively whether a handicap in Social-Emotional area existed. Second, informal observations and impressions of teachers and other team members who assessed the child were considered during eligibility decision making. Third, input from parents gathered during interviews by social workers and the school nurse about each child's behavior contributed to eligibility decision making.

Since January 1986, the Quadrant system has been replaced by the Personal-Social scale from the BDI as the principal tool for assessing eligibility in the Social-Emotional area. The Personal-Social scale gathers information from parents during interviews in six domains: adult interaction, expression of feelings, self-concept, peer interaction, coping, and social role. Parent ratings of their child's behavior in these areas are combined to obtain norm-referenced standard scores. Subjective data, such as the impressions of parents, teachers, and other team members, also were considered. One of the major reasons for switching to the BDI Personal-Social scale was to take advantage of the objective scoring system, making eligibility decisions less subjective. Criteria for program eligibility using the BDI Personal-Social scale involve a 1.5 SD discrepancy from age-referenced expectations in the social-emotional and readiness area, or a 2.0 SD discrepancy on the Personal-Social scale alone.

This year, the two psychologists at Program A have taken a more active role in social-emotional assessment. One of the psychologists devised several behavior checklists that have been completed by assessment teachers since January 1986 (see Appendix A-4). One of the psychologists uses a peer-referenced observation scale, standardized in the district's K-12 system, to assess social-emotional skills (see Appendix A-5).

Cognitive. Cognitive assessment is conducted only with children having concerns expressed in a referral or by an assessment team member in the cognitive area. About 5% to 10% of referred chilren are assessed in the cognitive area; the psychologists are primarily responsible for eligibility assessment in this area. The psychologists administered the Stanford-Binet Intelligence Scale (S-B) or Kaufman Assessment Battery for Children (K-ABC) to measure current intellectual functioning. Sometimes the Pictorial Test of Intelligence is administered instead of the S-B or K-ABC to children experiencing motoric and/or language problems. In addition, each psychologist often administers supplementary tests to confirm or further delineate cognitive functioning, such as the Boehm Test of Basic Concepts or a test of adaptive behavior. Eligibility criteria are based on results of a standardized intelligence test, and involve a 2.0 SD discrepancy from age expectations in the cognitive area, or a 1.5 SD discrepancy in the cognitive area and one other area. As in other areas, the measurement error of tests, situational, and qualitative factors are considered in the interpretation of test scores.

Exceptional Cases

Generally, children enter Program A when a handicapping condition is identified by the assessment team following a four-day classroom assessment. However, for about 15% of assessed children, the decision to admit the children is postponed pending further assessment over a six-week period. During this six-week assessment, children are placed in intervention classrooms, and additional information is gathered to facilitate eligibility decision making. Often children are referred for six-week assessment because information needed to make an eligibility decision was considered insufficient or invalid by the assessment team. For example, some children may behave too aggressively or in such a withdrawn manner that assessment results are judged to be invalid. One teacher described the four-day assessment process for some of these children as a "honeymoon" phenomenon, where the child's more typical functioning emerges only after a period of adjustment to the novel educational setting. During the six-week period, intervention teachers and other team members observe the child's behavior and may administer tests to facilitate an eligibility decision, which is made at the end of six weeks.

Children who have been found to be eligible for special education services in another school district may enter Program A without the usual assessment procedures. Also, the usual assessment procedures are waived for children who have undergone an assessment process judged to be similar to the one at Program A. These "direct referrals" from other agencies are reviewed and considered by social workers at Program A. During the past year, an effort has been made to reduce direct referrals, in part, by having Program A assessment teams travel to community sites to conduct assessments. Consequently, a higher proportion of Program A entrants have been through a similar assessment process this year.

If a student does not qualify for services in speech, for example, but the clinician thinks services are necessary, a variance request can be submitted to the District Supervisor. Such children must qualify for services at Program A in some other area. The speech clinicians said they seldom submit variances (1 to 2 times each year per clinician); they also indicated that the variances usually were approved.

Each year, about 15 children found to be eligible for Program A services do not attend the full program. Some parents do not follow through on enrolling their children, and others stop sending their children to school. In most of these cases, the children come from families experiencing a variety of social and economic problems.

Other Agencies

The assessment team cooperates with a variety of other agencies, as well as with other departments and schools within the district. They occasionally work with the School 2 Outreach Team when assessing multiply, physically handicapped children. Such assessments occur about two or three times a year. About eight times a year the speech clinicians conduct assessments with the Limited English Profiency (LEP) team employed by the district. In those cases, the speech/language clinicians assess children through an interpreter. The speech clinicians also work with the hearing-imparied assessment team at Program A, which includes a teacher of the hearing impaired, aide, social worker, psychologist, and audiologist. Each year about 8 to 10 children with hearing impairments are assessed. The number of hearing-impaired children assessed seems to vary considerably from year to year.

The assessment team also contacts direct referral agencies, such as DACs, day cares, and hospitals, to obtain information from people who have worked with or assessed the children referred to Program A for assessment. In the past year, Program A has made a concerted effort to obtain all available information from other agencies on children referred to the program before assessment begins. In previous years, problems occurred when assessment reports or medical information, for example, were not received until after assessments were completed. As mentioned previously, the assessment team has traveled to other agencies to conduct assessments during the past year. The district's Interagency Early Learning Committee involved frequent contact between the Program A Director and other administrators of city programs. The general goal of the committee is to promote interagency collaboration in service delivery, and reduce duplication of services. For example, a collaborative arrangement between the district and a county agency is being developed to assess and serve handicapped 3-year-old children next year.

Labeling Issues

Program A staff are sensitive to the potential harm that can be associated with diagnostic labels. Many children assessed at Program A come from disadvantaged backgrounds, and exhibit general developmental problems related to experiential factors. Some of these children may qualify for Program A services in several areas, such as readiness and social-emotional areas, or readiness and cognitive areas. These children may be given the "readiness" diagnostic label, since that label is considered to have fewer negative connotations than "emotionally disturbed" or "mentally retarded." However, intervention services would also be directed at areas of need in addition to the "readiness" area.

Intervention

Program Objectives

The long-range goal of intervention services at Program A is "to enable the child to succeed in the least restrictive educational alternative upon leaving the Preschool Program" (School District Information[1], 1980). In fact, about 90% of the children completing intervention at School 1 are placed in regular education kindergartens. Brochures and teachers emphasized a holistic approach to treatment, taking into consideration the child's strengths as well as weaknesses, and including the family in the assessment/treatment process (School District Information[1], 1985). In addition to addressing the special education needs of handicapped children, education in the context of the normal developmental needs of children (e.g., self-esteem, trust, safety) was emphasized by School 1 staff. Thus, teacher-identified goals varied among teachers, but included factors such as:

1. To the maximum extent possible, helping children to view themselves as capable and competent by building self-esteem.

2. To engender the feeling that school is a safe and worthwhile place to be, and a place to experience learning and enjoyment.

3. To help children learn how to be in situations where they can enjoy interacting with others.

4. To systematically expose children to a variety of ideas, materials, and situations.

The Program Director, teachers, and a brochure (School District Information[1], 1985) also emphasized the importance of play activities as a treatment avenue for maximizing the development of handicapped children. Play is viewed as the child's work, and the facilitating and guiding of play is viewed as an important teacher responsibility.

Participants

A maximum of eight children are placed in each intervention classroom, as state law dictates. Usually about six children are placed in classrooms in September, and class size increases slightly as more assessed children are admitted to the program. During the school year, an average of about 230 children receive intervention services for half-day sessions in 13 classrooms. Because children may enter School 1 as late as March, the duration of services varies from 2½ to 9 months. Children must be 4-years-old by the first of September, residents of city A, and handicapped to be eligible for the program. Consequently, all children attending the program are either 4- or 5-years-old.

The ratio of boys to girls is approximately 3 to 2. About half of the children belong to minority groups.

Services to children are coordinated by intervention teams, which meet once every week or two weeks. Intervention teams include the Early Childhood Special Education (ECSE) teacher, teacher aide, speech clinician, OT, social worker, and psychologist. Classrooms are staffed by an ECSE teacher, and a teacher aide.

Both severity and type of handicap are considered in making classroom placement decisions. Classrooms are organized by placing children with different handicapping conditions in each classroom. The two hearing-impaired classrooms are the exception, where children are grouped according to the severity of their hearing loss. Also, each eligibility assessment team assigns a global rating to each child using a 5-point scale on the degree of teacher intervention required to manage the child. The Program Director uses these ratings to balance assignment of children requiring high levels of intervention among classrooms. The Program Director said that a multicategorical classroom grouping of children, and a professional team approach to special education lead to increased social learning opportunities for children, and more comprehensive assessment/treatment procedures. Teachers also spoke positively about use of a multidisciplinary team approach, which encourages professional learning through sharing of diverse experiences and areas of expertise.

A survey sent to parents in February 1986 indicated that 68% of parents had visited School 1 three or more times since September, and 74% of parents had communicated three or more times with their child's teacher. Typically, parents visit School 1 on the first day of assessment sessions, on the seventh day of assessment sessions to attend Student Support Team (SST) meetings, and when IEP revisions are made during Periodic Review meetings. Open house meetings with parents also are scheduled several times during the school year. Twelve percent of the parents said that some member of the School 1 staff had visited their homes. All parents surveyed reported feeling satisfied with their child's teacher, and 98% of parents were satisfied with their child's educational program and the School 1 program overall.

Personnel and Roles

The professional staff at School 1 function on an equal footing as members of assessment/intervention teams. Staff members are allowed considerable discretion in determining what they do and with whom they work, according to teachers. Each teacher supervises the aide assigned to the classroom. Aides function in roles similar to teachers, although their duties vary depending on the working arrangements between particular teachers and aides. Generally, aides are involved in less planning activities and interactions with parents than are teachers. Other professionals team with several classroom teachers for assessment and consultation during intervention. Teachers function as case managers for children in their classrooms. This role involves overseeing the educational progress and program for individual children. Psychologists do not work with children directly, but consult with social workers, or teachers and social workers dealing with behavioral and social-emotional interventions. Speech clinicians, OTs, and social workers consult with teachers, and also provide direct service to some children. They may work with individual children or small groups. All professional staff hold relevant state licensure, except for OTs. Because there is not state licensure for OTs, they are certified by a national professional organization.

Service Delivery Modes

Determining who works with a child and in what capacity (direct or indirect service) primarily depends on the area of eligibility and the severity of the child's educational needs. In readiness, cognitive, and social-emotional areas, children qualify for direct or indirect service if they exhibit a 33% delay or a 2.0 SD discrepancy relative to age expectations based on eligibility assessment results. Children exhibiting a 25% delay or a 1.5 SD discrepancy are eligible for indirect services. Similar criteria apply to eligibility for direct and indirect service in the speech/language area (see "Diagnosis to Entry" section). ECSE teachers and aides are primarily responsible for intervention in the readiness and cognitive areas, and provide direct and indirect service to individual children and small groups in readiness and cognitive skills (e.g., communication, self-help, thinking, visual-motor, school readiness, general knowledge). Social workers and teachers are responsible for direct service in the social-emotional area, speech clinicians in the speech/language area, and OTs in fine-motor and gross-motor skills. However, these professionals may serve children indirectly by consulting with teachers and aides, who work directly with children. In addition, children may be served indirectly in areas outside of those in which they qualify. For example a child with a handicap in the social-emotinal area may be identified as needing service in communication skills. The communication needs might be addressed in a language group conducted by the teacher.

Social workers offer direct service to children in the form of individual or small-group counseling, often in the classroom or gym. Social workers also may serve children indirectly in the social-emotional area by consulting with teachers and assisting with development of behavior plans. Often, who delivers service in the social-emotional area depends on which team member feels most comfortable, and is judged to be most appropriate for the role. For example, a teacher may address the social-emotional objectives in children in the classroom, and the social worker may focus more on outreach work with parents. Typically, these decisions are formulated in intervention team meetings. Social workers also provide indirect service by offering parenting groups (i.e., STEP) to parents.

In the speech language area, children who meet two out of the three eligibility criteria may receive direct (Level III) or indirect (Level II) service from the speech clinician, and those children who meet only one of the criteria may receive indirect (Level II) "Monitoring" services (see criteria in "Diagnosis to Entry" section). For children meeting two out of the three speech/language criteria, the decision about whether direct or indirect service will be provided depends on judgment of the speech clinician and intervention team, taking into consideration factors such as the child's needs, expertise of team members, scheduling and caseload constraints.

Children receiving direct service in the speech/language area are seen by the speech clinician three to five times per week individually, or in small groups of two to eight children. For indirect service, the speech clinician designs and supervises the instructional program, sometimes uses an initial six-week period of direct student contact, specifices objectives and goals, and consults at least one monthly with person(s) responsible for working with the child. Speech clinicians also may work with an entire class, which is also considered indirect service. In addition, monitoring, generalization, and follow-up are considered indirect (Level II) services.

Children who are eligible for speech only services are bused into School 1 for speech therapy services, or attend similar sessions at a school in their neighborhood, if available.

Eligibility for direct and indirect OT services are patterned after speech criteria. Children must qualify for services (be handicaped) in order to receive direct or indirect OT services. Eligibility for occupational therapy also depends on whether children qualify as a result of assessment by an OT (see "Program Assessment" below). OTs work with children (usually in pairs) twice a week for 20-minute sessions. Children they tend to see in one-to-one sessions include those with CP, spasticity, hemipalegic, hearing-impaired children who use sign language, and/or children exhibiting highly distractible/impulsive behaviors. OTs also provide indirect service by consulting with teachers through intervention team meetings.

Intervention team members also provide indirect service to mainstream settings (e.g., private day cares) and parents. Consultation may involve a variety of tasks, such as interpreting assessment results, recommending activities or management strategies , and coordinating delivery of services. Regular contact occurs between School 1 staff and a number of other agencies working with handicapped and disadvantaged children (e.g., DACs, Headstart). Social workers often have the most contact with parents and other agencies.

Program and Progress Assessment

Program assessment is conducted to identify educational objectives for individual children, and the type and amount of available services children receive. Children eligible for direct or indirect services are assessed during the first six weeks of intervention. Teachers use a variety of techniques to assess readiness, cognitive, communication, and social-emotional areas; these techniques vary considerably among teachers. Some teachers use narrative logs or checklists they have developed to summarize specific communication and readiness skills children have mastered. Some teachers use the Quadrant System (discussed in the "Diagnosis to Entry" section) to assess social-emotional skills. Other teachers may identify specific behaviors for monitoring progress. For example, with a sad appearing child, the teacher may tally the number of times the child smiles during a guided play activity. All teachers use completion of IEP objectives and goals as a means of monitoring progress. Progress monitoring also may involve any of the procedures used in program assessment. Teachers vary in their degree of reliance on standardized tests during intervention. Some teachers administer an instrument, such as the

Brigance, every three months to document progress, and others rarely use formal testing. More often, teachers administer a test at the end of the school year.

OTs are in a unique position, because motor skills do not constitute an area of service eligibility. Instead, motor skills contribute to the readiness area. Consequently, children must qualify for services (be handicapped) in order to receive OT services, and also be deemed eligible by an OT assessment. Handicapped children with suspected motor problems are referred for OT assessment by some member of the assessment or intervention team. Referral agents at School 1 often gather considerble data before referring children for OT assessment, according to OTs. The OTs administer the Miller Assessment for Preschoolers (MAP), which assesses neuromotor skills, especially foundation skills for development, such as balance, muscle tone, kinesthesia, tactile processing, etc. Children who score below the fifth percentile on the Foundation or Coordination components of the MAP, or on the MAP total score, are deemed eligible for OT services. The OTs also administer the Beery-Buktenica Visual-Motor Integration (VMI) Test to most children they assess. The Gesell is administered if the instrument is judged to be more appropriate for a particular child (especially EMR children), or if age scores are needed to support eligibility decisions.

Ongoing clinical monitoring of progress for children receiving OT services is conducted by OTs on an informal basis. The number of IEP and Instructional Objective Plan (IOP) objectives for occupational therapy are noted to assist with evaluation of progress and therapy needs.

As mentioned above, eligibility for direct or indirect services in the speech/language area is determined in part by results of eligibility assessment. Also, assessment in the first six weeks of intervention is used to determine the level and type of intervention to be implemented. Typically, speech clinicians obtain an unstructured language sample, and administer several tests and scales that are approved by the district, and judged to be relevant to assessment/intervention questions. Then, speech clinicians decide whether the child should receive direct or indirect services and the type of intervention (e.g., small-group versus individual services). Specific IEP objectives are written, along with a more specific IOP, using a bank of objectives provided by the district.

At the end of the school year, children receiving speech/language services are posttested by speech clinicians on the school district language measure to assess progress. Also, teachers administer a school language curriculum test to all children at the time of program entry, and again at the end of the school year. This test, which measures basic vocabulary and concepts, was developed by School 1 staff.

Generally, teachers view eligibility assessment procedures as being adequate for placement purposes, that is, for identifying handicapped preschoolers and providing a general picture of the child's strengths and weaknesses. However, child behavior and apparent child needs may change following the four-day assessment. For example, one child did not talk during assessment, which complicted efforts to determine many of her educational needs. Only after a period of time in an intervention classroom, did the child speak often enough so that her teacher felt confident that the child's educational needs had been identified.

Content

Determining the amount of time children actually spend in various content areas is complicated because the time varies as a function of child needs, teacher discretion and judgment, and how one tries to define and gauge time spent in specific areas. For example, one teacher may use a manipulative activity to assess and facilitate a child's visual-motor skills, understanding of verbal instructions, and also to help the child deal with frustration and expression of anger -- all more or less at the same time. The focus of curriculum content is determined by the individual needs of children in the classroom. Sometimes children in a paricular classroom exhibit an overriding or dominant area of weakness, such as language skills. In such cases, the teacher may develop a language enrichment theme for the classroom curriculum, using consultation support from the speech clinician, for example.

For scheduling purposes, classroom activities are divided into areas that typically include guided play (about 60 minutes), snack (about 15 minutes), gym (about 30 minutes), and one or two group meeting times (about 20 minutes each) -- one for language activities, and one for stories, songs, fingerplays, etc. Teachers spend considerable time in planning how their classrooms will be organized with tables, media, manipulables, activity centers, etc. to foster the type of experiences and interactions they want children to have.

The assessment team case manager writes the initial IEP for children found eligible for programming at School 1. This first IEP is written in general terms, outlining the needs of individual children in broad areas, such as cognitive, communication, self-help skills, etc. Once the child is placed in an intervention classroom, the ECSE teacher takes over responsibility for case management, and for assessing the child in more depth over a six week period. At the end of six weeks, the teacher writes an IEP and IOP specifying in more detail the objectives and goals for each child.

Periodic Reviews

Periodic reviews of pupil IEPs must be conducted every six months. Typically, teachers review and update IEPs in January or February for children who entered the program in the fall. Depending on the extent of progress, IEPs may also be modified more frequently. Changes in the type or level of intervention service require that a Periodic Review be conducted.

Influences on the Program

A variety of intangible factors have had an influence on services provided at School 1, although their impact is difficult to determine. The Program Director and staff have been working on planning for the extension of special education servies to 3 year olds (beginning Fall, 1986). Next year's budget will include funds for an additional assessment team and case managers needed to identify handicapped 3 year olds. A staff development grant will be sought to facilitate assessment next fall.

In the spring, the Program Director informed the staff that the program will move to another building in September 1986 because of anticipated enrollment increases that will require use of School 1 as an elementary school. In May the staff was informed that the program will be housed, at least for a three year period, in a former junior high school in the district. A number of staff concerns have been identified and dealt with concerning the move. Still, most staff members considered the facilities at School 1 to be excellent, and expressed some concern about the new building, which is undergoing renovations during the summer months.

Since Fall 1985, intervention classes have been on a five-day per week schedule, rather than the previous four-day schedule. The schedule change intensified the classroom intervention experience for children, but also left the staff with less time for ancillary duties (e.g., paperwork, meeting time, parent education classes). Many teachers would like to have more time for involvement with parents.

Exit and Follow-Up

Exit

Because School 1 serves only handicapped children who are 4 years old by the first of September, all enrolled pupils exit the program at the end of the school year in June.[2] About 90% of the 232 pupils who attended School 1 in 1985-86 exited the program at the end of the school year. Thus, the principal criterion for exiting School 1 is completion of the program, or in another sense, becoming too old for the program (i.e., 5 years old by September 1).

Out of about 210 children exiting School 1 in June 1986, roughly 190 children (90%) were placed in regular education kindergartens for the following year. The remaining pupils were placed in one of several Level IV (special class) special educaiton settings. There are no Level V (special school) special education placements for School 1 graduates.

For a child to be considered for a special education kindergarten placement, School 1 intervention teams must present assessment and pupil progress data, similar to data gathered during eligibility and program assessment, at a Special Education Referral Coordinating Committee (SERCC) team meeting in the spring. SERCC teams include special education adminstrators and professionals from the school district, the child's parent, and the School 1 Program Director and intervention team members involved in the case. The decision to place a child in a special education setting rests on the judgment of the SERCC team about the most appropriate placement to address the educational needs of the child.

Exit During the School Year

About 20 children (10%) deemed eligible for special education services at School 1 exited the program during the school year. There are essentially three ways that children exit during the school year: (a) by completing all IEP objectives and being considered able to function successfully in a less restrictive setting; (b) by a parent decision to not enroll their child or send their child to school; and (c) by moving from the school district. Roughly equal proportions of children exited School 1 by those three routes.

Sometimes, without explanation, parents do not send their child to School 1. For a variety of reasons, parents may not put their child on the school bus. In such cases, the school clerical staff try to contact parents by letter, and if no response is obtained, by telephone. Unless a justifiable explanation for truancy is provided by parents, the child is dropped from the School 1 rolls after missing 15 consecutive school days, and a letter is sent to parents explaining that they must re-register their child in order to attend School 1.

Children who exit School 1 after completing all IEP objectives often are placed in community agency programs, such as Headstart or a private day care. Pupils who exit this way tend to be less severely handicapped, and demonstrate notable progress while attending School 1. The decision to exit the child is made through intervention team meetings leading to a Periodic Review meeting to discuss the exit decision and placement alternatives. Factors considered in deciding to exit the child may include the availability of appropriate alternative servcies, the needs and finances of the child's family, as well as the child's educational needs and progress.

School 1 staff attributed the relatively low proportion of children exiting the program by completing IEP objectives to a variety of factors:

1. Because the School 1 program is nine months long, few children progress sufficiently in that time to warrant a mainstream type of placement.

2. Because School 1 eligibility criteria are relatively stringent, most children exhibit serious problems that are not "cured" in a short time.

3. Alternative less-restrictive placements are limited in number, partly because the district has no Level IV transition program for preschoolers (School 1 is a Level V program). However, plans for a transitional preschool program have been announced publicly by the district. The proposed program would serve "high risk" children, as well as some handicapped and nonhandicapped children.

Follow-Up

School 1 staff do not conduct follow-up procedures for children leaving the program in June. Special education termination procedures require that children be followed up within one year after services are terminated. There are no data available documenting how and whether these follow-up procedures are conducted. The pupil's file is sent to the receiving school, and a record is kept at School

1 of where pupil files were sent. A computerized record of children who attended School 1, including descriptive information (e.g., type of handicap, ethnicity, sex, referral reason, etc.), are stored on magnetic tape.

Several years ago a special education administrator tracked mainstreamed School 1 graduates through kindergarten to see how many children re-entered special education during that year. Using computer records, the administrator found that only about 20% of School 1 graduates attending regular education kindergartens received special education services. Hence, the follow-up data suggested that most School 1 graduates complete kindergarten without experiencing educational problems that are serious enough to warrant special education services.

For children placed in mainstream kindergartens, the social worker at the receiving school is given a list of students who attended School 1. Because district administrators were concerned that kindergarten teachers may be predisposed to see problems in children coming from School 1, the teachers are not automatically informed which children attended School 1. But teachers may obtain pupil records from School 1 by asking the social worker for them.

Follow-up services may be conducted with children who leave the program during the school year. Depending on the particular case, intervention team members may provide follow-up consultation to parents or other agencies working with the child. Consultation arrangements are worked out through intervention team meetings that lead to termination of services at School 1. Such follow-up consultation services may range from answering questions over the telephone to site visits.

Summary

Program A reflects an approach to early childhood special education services that is designed to meet the needs of a large population. The process is systematic in appearance. Intervention is relatively short term in duration unless severe difficulties exist or sensory or physical handicaps exist. Despite the urban setting and the large numbers of children screened, assessed, and served, the program maintains a data-based approach to intervention. Attempts to have been made to monitor the effects of the system and of removing labels and identification of students before they enter kindergarten.

Chapter 3: Program B

Jill A. Weiss

Program B is an early childhood special education program that began in 1977. The program is located in a community center, along with programs serving nonhandicapped preschoolers. Approximately 35 children were enrolled in Program B during 1985-86. Figure B-1 is a flowchart of the major steps and decision points in the screening, asssessment, and decision-making process within the district and Program B.

Program Description

Community Characteristics

Program B is located in a suburban school district about five miles outside the city limits of a large urban area. The school district serves a population that is largely middle to upper-middle class, and for the most part one that is college educated. The district's population is largely white (98%). Almost half of the families (49.4%) have an income above $30,000, and unemployment rates are low. Additional details on characteristics of the community in which Program B is located are provided in Table B-1.

The school district's average daily membership (ADM), which is the average number of pupils in membership during the school year, is 6,720 (Minnesota Department of Education, 1985). With 450 children counted as enrolled in kindergarten, 2,609 in elementary grades, and 3,653 in secondary grades, the ADM for preschool handicapped students in 1983-84 is recorded as 8. Program B reports that it has 38 pre-kindergarten children enrolled in its 1985-86 program, and that enrollment has not changed significantly in the past several years.

The administrator of Program B described several characteristics of the community that might contribute to a relatively high referral rate. One is the community's high value on academic excellence. Many parents are willing to invest in early education to ensure subsequent achievement. Also, adequate social and medical services provide a referral base to the program. Moreover, a private school in the area has a long history of providing day care, nursery school, and special education services to children in this community. Consequently, most of the community is very aware and accepting of services for preschoolers with special needs.

A school social worker for the program commented that there was a general concern in the area for the "whole" child. A widely held community value is the realization that the child is part of a larger system: family, school, and community. These beliefs are incorporated into the program's philosophy of parent involvement. A great number of parents in the district are high achievers. This has a potential impact on the program that may work in one of two ways: (a) some are anxious to enroll their children in order to lessen future problems, and (b) others are resistant to the idea that there might be some problem that could potentially affect their child's future achievement.

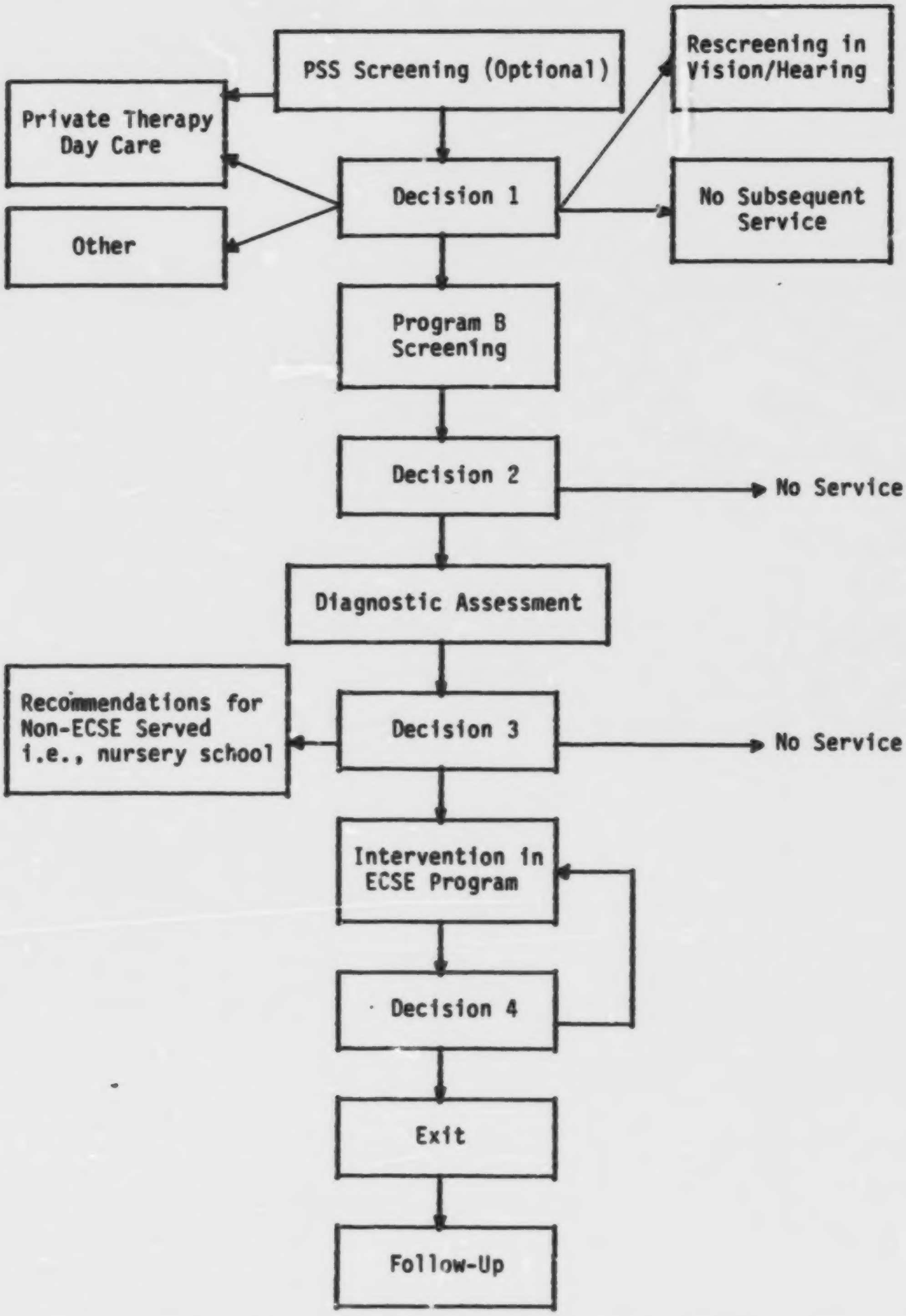
PSS Screening (Optional)
Rescreening in Vision/Hearing
Private Therapy Day Care
Decision 1
No Subsequent Service
Other
Program B Screening
Decision 2
No Service
Diagnostic Assessment
Recommendations for Non-ECSE Served i.e., nursery school
Decision 3
No Service
Intervention in ECSE Program
Decision 4
Exit
Follow-Up

Figure B-1. Major stages and decision points in Program B's early special education assessment and decision making process.

Table B-1

Demographic Characteristics (1980 Census Data)

Race

97.7% White
.91% Black
1.39% Other

Occupation

Managerial/Professional: 32.57%
Tech/Sales/Admin: 37.53%
Services: 11%
Farm/For/Fish: .32%
Other: 18.8%

Average Number of Children

Age	Number of Children
15-24 years	.09
25-34 years	.36
35-44 years	2.29

1979 Family Income

Less than $2,500	.82%
$2,500 - $7,499	3.59%
$7,500 - $12,499	8.14%
$10,000 - $14,999	8.43%
$15,000 - $22,499	16.3%
$22,500 - $29,999	17.53%
$30,000 - $39,999	21.15%
$40,000 - $49,999	10.48%
$50,000 - $74,999	11.45%
$75,000 or more	6.37%

Employment

Male:	Employed	80.87%
	Unemployed	2.41%
	Armed Forces	.09%
	Not in Labor Force	16.64%
Female:	Employed	61.33%
	Unemployed	1.14%
	Not in Labor Force	37.53%

Poverty Status

Above Poverty Level: 97.48%
Below Poverty Level: 2.53%

Education

Years of school completed by those 18 years and over
Elementary: 13.25%
High School: 35.09%
College (1-3 years): 24.41%
(4 or more years): 27.25%

Another observation made by an early childhood teacher is the small percentage of minority children in the program, reflecting a lack of diversity in the general population. There is a strong academic focus in kindergarten, where children are learning skills that previously were the turf of first grade teachers. Many of the Program B children enter a regular kindergarten program, so they must be prepared to handle its curriculum.

Physical Setting

Program B is located in a community building that also houses day care and nursery school programs. Two classrooms and an office comprise the Program B space. There is close proximity to programs serving nonhandicapped preschoolers, but isolation from regular elementary education classrooms. The Program B population is the only school district population served in the community building.

There appears to be a general consensus concerning the influence of the physical setting on the program. The majority of the staff feel access to the day care/nursery school programs is an advantage. Several children attend a combination of programs. Also the young population served in this building may feel less threatened than they would if they shared space with older students. However, being housed separately from the regular education programs is a disadvantage in that elementary school teachers are not very familiar with the program and distance limits some mainstreaming opportunities. The length of the bus ride to the community center is an issue for some of the children.

The two Program B classrooms are quite different in size. One is extremely large; the other is an average size room. The teacher with the large room thinks that it is too spacious for the small number of children (6) in the room. The teacher of the smaller room believes that the smaller size fits her needs and the needs of the children well. The Program B coordinator expressed concern that space is a limitation in the community building. There are not enough classrooms if the program is to expand. The community center rents out space and can ill afford to give away classroom space. Despite this disadvantage, there is an appreciation for the present location because for several years the program moved from location to location when space was needed to serve regular education students. The office has two small adjoining rooms, but basically the entire faculty share a common work space. The work area was described by one professional as "grossly inadequate." Lack of individual work space leads to greatly reduced efficiency, increased stress, and increased amounts of work needing to be completed at home. However, another professional noted that the amount of office space allotted to the staff has increased in the past few years.

All parents in the program were sent questionnaires in which they were specifically asked to report their opinion of the physical setting. There was about a 20% response rate, with all speaking highly of the setting. Positive comments included the following:

1. The facility is complete with a gym, cafeteria, conference room, playground, and classrooms.

2. The building is in a good neighborhood.
3. The environment is scaled down to "kid-size" and is bright and cheerful.

Organization and Staff

Eleven individuals work in Program B. The designations and roles of these people are as follows:

- Program Coordinator/Social Worker (7/10 time)
- Secretary
- Full-Time Special Education Teacher
- Full-Time Professional who functions as ½ Time Teacher/½ Time Speech Pathologist
- Full-Time Speech Pathologist
- Part-Time Occupational Therapist (4/10 time)
- Full-Time Aide (30 hours)
- Part-Time Aide (15 hours)
- Part-Time Social Worker
- Nurse
- Psychologist

The amount of experience of the staff ranges from 1 to 15 years. Bachelor and master's degrees in the areas of education, speech/language, and social work are represented. Special interest areas among staff include poverty issues, self-esteem, and the development of language assessment tools.

The program includes four classes, with approximately 6-8 students in each class. There are two morning and two afternoon classes. Each class is staffed by a qualified teacher and a speech pathologist or an aide. The speech pathologist and the aide rotate so that at all times there are at least two staff members working in each room. The speech pathologist may help conduct large group langauge activities or work with students on an individual basis.

The students in Program B attend school four half-days per week. The fifth day, Friday, is designated for team meetings and assessments. The daily programming is similar in each classroom.

The lines of authority in this program begin with the district superintendent and the director of special education, followed by the preschool coordinator. The program social worker, therapists, teachers, and aides are supervised by the coordinator. However, quite a bit of autonomy is evident, with all staff members sharing equally in decision-making processes. In fact, there was considerable agreement about the structure and interaction style of the staff. The program is described as one that is very flexible and that fosters creativity, the sharing of ideas, and team work. As one staff member stated, "The politics and jockeying for position really feels absent here." However, some concern was expressed regarding a lack of clear role differentiation -- of who does what. Also, due to the small program size there is an overlap of responsibilities. The same team is responsible for carrying out assessment and intervention procedures. This, according to one individual, has the potential for leading to work overload and stress. Overall, professionals in the program appear enthusiastic, very concerned about student welfare, and appreciative of the sharing and team work promoted by the coordinator.

History/Rationale/Philosophy

Program B, in direct response to P.L. 94-142, began in 1977 with a social worker, one full-time speech pathologist, one full-time teacher, and one part-time aide. A nurse was incorporated into the system and social work time was increased during the second year. The program was developed to meet the needs of three and four year old children with difficulties in any of the following areas: vision, hearing, physical coordination, speech and language, behavior, and social interaction.

The goal of the Program B classroom is to provide a supportive setting in which children can participate in activities appropriate to their level of development. As stated in the early childhood program handbook:

> These activities are planned to stimulate communication and language, to build individual and group social skills, to provide experience in fine and gross motor areas, to promote the acquisition of general knowledge, and to teach some pre-academic skills.

An integral part of the program, one that has been emphasized since the first year, is a belief in parent involvement. Parents are regarded as the first and foremost teachers. All families are involved in the program to some extent. Regular on-going contact between family and school is maintained through the following:

1. Parent conferences
2. Weekly parent support groups
3. Special family night programs
4. Occasional home visits by social worker and/or teacher
5. Classroom visitations
6. Home/school notebooks

The parents were surveyed and all those who responded (20%) were overwhelmingly enthusiastic about the parent component of the program. They appreciated the staff's recognition of their role and the encouragement to visit the classroom or participate in the parent group.

Other Influences

The assessment process most recently has been influenced by the new "Early Childhood Handicapped" label approved by the state. Preschoolers now can be served after being identified only as "handicapped." It is no longer necessary to identify specific handicapping conditions such as learning disabled, emotionally disturbed, or mentally retarded. Consequently, youngsters who may previously have been given a categorical label (ED, LD, etc.) may now be placed in generic programs without the risk of premature labeling. However, not all state recommendations have been adopted by the district in which Program B is located. For example, the high school serves children with only articulation problems, which is contrary to state policy.

Funding

Information about Program B's budget and funding was obtained from the district's Director of Special Education. The program is funded by money from state, federal, and local sources. State and federal funding sources were the same as for other programs. In addition to these sources, local funds were discussed as another source of funding for Program B. These district funds reportedly make up the difference between the program's expenditures and the total amount of funding received from state and federal sources. The Director noted that this amount was not to exceed 10% of Program B's expenditures for a given year.

Screening and Referral

Preschool Screening by PSS

A formal screening program is carried out by the Preschool Screening Program (PSS), which has primary responsibility for screening all the three and four year olds in the district to identify children who may be in need of further assessment and possible special education services. Screening takes place in September through November and March through May. Sixteen children are scheduled per day on Tuesdays and Thursdays during these periods. Although appointments average 30 minutes per child, the schedule is not adhered to rigidly. Families may have to wait for a short time if a child's screening or a parent interview takes longer than anticipated.

Child find. Families of all children between the ages of 3½ and 4½ are sent letters inviting them to bring their child in to be screened. Their names are from state census forms. In addition to individual family contacts, many community-wide notification approaches are used. This particular school district regards the process of notifying the public of special education services as a priority. Each year an attempt is made to inform all relevant organizations and media sources of the existence of the program. Below is a sampling of these contacts:

Media

Elementary Newsletters
Nursery School Newsletters
Community Education Newsletters
School Counselors' Newsletters
General Community Newspapers

Community Outreach

Nursery Schools
Child Guidance Clinics
Medical Centers
Private Schools
Day Care Families
Mental Health Centers
County Family Service Agencies
Private Family Service Agencies

District Sources

Kindergarten teachers (monitors "missed" kids)
Elementary Principals
Elementary Support Staff
Pre-kindergarten Programs
Parent-Teacher Organization
Special Education Parent Advisory Group

When eligible families fail to respond to the first letter, a follow-up telephone call is made. After this step, no further effort is made. The school nurse stated that families are not obligated to have their children screened; consequently undue pressure is avoided.

Sequential steps in the PSS screening process. Following the initial process of locating eligible families, individual appointments are made by telephone. The PSS coordinator is sensitive to parent needs and quite flexible about appointment times. Prior to the actual screening appointment, parents are sent a health history form and a physical exam report. The former is completed by the parent, the latter by a physician. Families are strongly encouraged to have the preschooler examined by a physician in order to supplement the health screening carried out by volunteers.

When parents arrive for the appointment, they are greeted and registered. At this time, the health history and physical exam reports are collected. Parents are given a survey in order to evaluate the screening program as well as guide sheets describing effective behavior/home management ideas and healthy snack suggestions.

Trained volunteers are each assigned to one child during the screening process. The district originally used a station model, in which each volunteer was assigned to a particular station (e.g., vision testing) and the preschoolers rotated from station to station. It was believed, however, that these young children would feel more relaxed if assigned to only one unfamiliar adult. Therefore, the volunteer now completes all parts of the assessment process with the same youngster.

When screening for a given child is completed, a school nurse meets with the parent to discuss the testing results. These "exit interviews" may run from 15 minutes to 1 hour depending upon the number of concerns and questions raised by the parent. Time is taken to respond immediately to parental concerns even if other parents are kept waiting. Two nurses are responsible for carrying out the exit interviews. The nurses sit side by side, separated by a screen, each consulting with a different family. The proximal seating arrangement facilitates consultation between the nurses when necessary.

There is an attempt by PSS to schedule families on the days that the school nurse from their child's home school will be present. The district believes that families will be much more at ease when their child begins school if parents are already familiar with the nurse. Additionally, this system provides the school nurse with the opportunity to more closely monitor children with potential problems. In support of this system, PSS funds pay for a substitute nurse to fill-in at elementary schools three days in the spring and three days in the fall to allow regular nurses to be involved in the screening program. Children who need to be rescreened are brought to the home school and evaluated by the now familiar school nurse. It must be pointed out, however, that the logistical problems in matching each child to the appropriate school nurse is great and a match is not always accomplished.

If a child fails a vision or hearing screening, that child is rescreened in two weeks. A referral is made to the pediatrician following a second referral. Parents of youngsters who fail the speech screening are given an option to go through the assessment process of the early childhood special education program (ECSE) or to receive a private speech therapy evaluation at their own expense. Families of children failing the developmental screening most often are referred to the ECSE program for further evaluation.

Criteria for referral. Children are screened in the following developmental areas: (a) speech/language, (b) motor, (c) social-emotional, (d) cognitive, (e) hearing, (f) vision, and (g) height/weight. The Denver Developmental Screening Test is used to assess the first four areas. Delays on the Denver in two areas not including speech/language (i.e., motor, social-emotional, and cognitive development) result in a referral for further evaluation. In the area of speech/language, a speech worksheet is used along with the Denver. The worksheet is used to record articulation and sentence structure errors. Two delays on the Denver and one delay on the speech worksheet result in a referral in the communication area.

Vision is screened using a STYCAR chart, cover test, and corneal reflection test. The nurse retests any youngster meeting one of the following criteria: (a) eye related problems are observed/reported, (b) failure of cover test or corneal reflection test, (c) visual acuity of 20/50 or worse using STYCAR chart, (d) two line difference or 10/25 or worse using STYCAR chart.

A pure tone audiometer is used in the process of testing hearing. Referral is made on a failure of 5db in a child with a threshold falling below the bold line on the screening audiogram.

Additionally, height and weight measures are recorded. Children falling outside the normal range may be referred to their pediatrician.

PSS staff and training. From 15 to 20 volunteers are involved in the screening process each year. There is a turnover of 3 to 5 new personnel each spring and fall. The State Department of Health assumes responsibility for training the volunteers in vision and hearing testing. The preschool screening coordinator, an Early Childhood licensed school nurse, trains the volunteers in the use of the other screening instruments, such as the Denver Developmental Screening Test.

Training takes place during a one-day workshop. Initially, neophyte volunteers work with a trained volunteer until they feel comfortable in carrying out the entire screening process independently. Due to a relatively low volunteer turnover rate, the screening process generally is conducted by well-trained, experienced volunteers.

Screening results for 1985-86. During the 1985-86 school year, 546 letters were sent out to eligible families prior to the fall and spring screening sessions. Of the 546 families contacted, 358 (65%) participated in the screening process.

Following screening, 41 of the 358 (11%) were referred to the ECSE program for further evaluation. A breakdown of the reasons for the 41 developmental referrals is presented in Table B-2. As is evident in the table, most referrals were for speech/language difficulties. Some children were referred in more than one area (most of these were failures in multiple areas of the Denver Developmental Screening Tests).

Originally, 15 children failed the vision test. After a second screening two weeks later, six failed again and were referred to an eye doctor.

A total of 77 children (21%) failed the pure tone audiometry at the first screening. Of these 77, 28 (36%; 7.8% of all children screened) were referred to a physician following rescreening. The large number of false positives at the first screening is related to the fact that it is difficult to teach such young children how to respond during the hearing test. However, even with the number of false positives, the nurse commented on the relatively high number of children eventually referred to a doctor for further hearing tests. Ear infections is not uncommon in this age group. One child this year was found to have a tumor behind his ear drum contributing to hearing loss. Another was found to be in need of a hearing aid. Therefore, the coordinator feels the audiometer test is beneficial in that a few children with very serious physical impairments have been identified early.

ECSE Program Screening

In contrast to PSS, Program B functions under the auspices of special education and is specifically designed to address the needs of 3 and 4 year olds suspected of having a handicapping condition. The inclusion of 3 year olds is required in the 1986-87 school year, but this district had already incorporated this group in the spring 1986 screening program. Functions of the early childhood program include diagnostic assessment, formulation of educational objectives, and program implementation. A schematic representation of the steps and conferences occurring in Program B decision-making is provided in Figure B-2.

Table B-2

Reasons for Developmental Referrals from District B's PSS Program

Referral Area	Number	Percentage[a]
Speech/Language	36	58.1
Gross Motor	8	12.9
Fine Motor	7	11.3
Social-Emotional	11	17.7

[a] Percentage is based on the total number of referral areas cited (N = 62). These exceed the number of children referred (N = 41) because some children were referred for problems in more than one area.

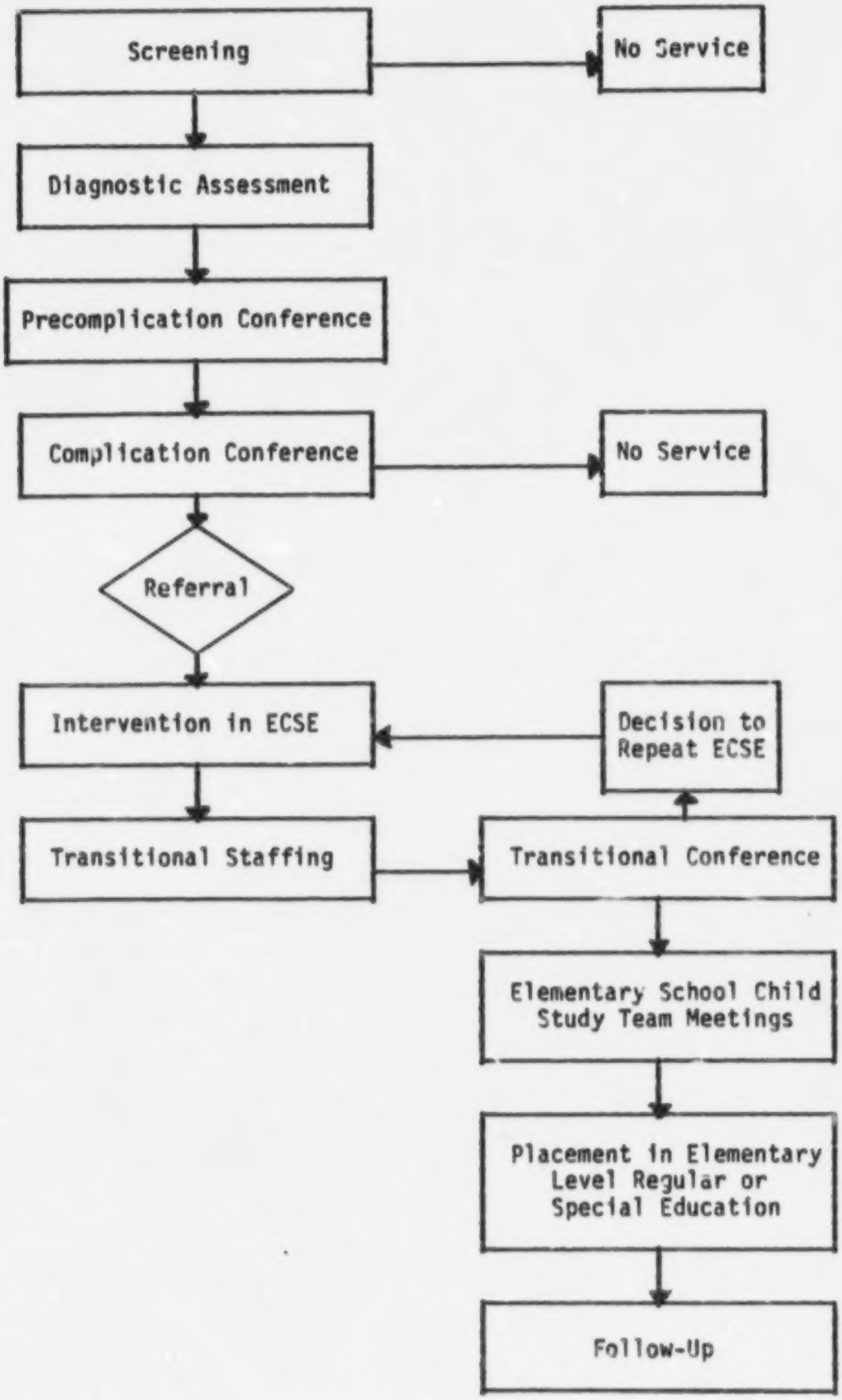
Screening
No Service
Diagnostic Assessment
Precomplication Conference
Complication Conference
No Service
Referral
Intervention in ECSE
Decision to Repeat ECSE
Transitional Staffing
Transitional Conference
Elementary School Child Study Team Meetings
Placement in Elementary Level Regular or Special Education
Follow-Up

Figure B-2. Flowchart of activities in Program B.

When children are referred to Program B, some areas of development may be screened, others assessed. This screening is not equivalent to the one carried out by PSS. Screening, as defined by the ECSE program refers to the process of "attending to" or observing a developmental area without utilizing standardized assessment tools. If a certain area (e.g., motor) does not appear on the surface to be a problem, a quick screening will be done by the Program B staff prior to or instead of a complete assessment. The advantages are that it is a time saver if a complete assessment is not warranted and an extensive report is not required.

A disadvantage of the Program screening procedure may be the lack of clarity of what constitutes screening versus what constitutes assessment. Generally, a one hour evaluation session involving observations of behavior and language is referred to as a screening, whereas a more in-depth two week diagnostic classroom placement (usually involving standardized testing) constitutes an assessment. However, these terms occasionally are used interchangeably, thereby creating some confusion. For clarity within this chapter, "program screening" will be used to refer to a one hour informal evaluation, and "assessment" will refer to a two-week diagnostic placement. The following is a description of the sequential steps of the screening/assessment process within Program B. The referral sources and intake procedures are identical for the child who is screened and for the child who is screened and later assessed.

Source of referrals. A review of data from 1981-83 revealed that children are most often referred to Program B by a parent, physician, nursery school teacher, or PSS. An analysis of a sample of 62 referred youngsters suggested that approximately 60% were referred by PSS, 20% by parents, 5% by physicians, and the remainder by personnel in day care programs or nursery schools, relatives, babysitters, or other concerned persons. The time of the year is an important determinant of the referral agent. In the spring and fall the source of referral is often PSS. Midyear, most referrals originate as a telephone call from a concerned parent who has heard about the program.

Intake procedure. After receiving the referral, an intake telephone screening is conducted. At this time, the social worker sets up a home visit with the parent. A thorough developmental history, as well as a description of the parents' perception of the problem, is gathered during the home visit. Samples of the intake form and developmental history questionnaire are provided in Appendix B-1.

Children who have not gone through PSS often are sent to the PSS coordinator prior to being evaluated by the Program B staff. Results on the Denver Developmental Screening Test then can be compiled with data collected later to provide a more complete picture of the child's needs and strengths. Although the bulk of preschool screening through PSS occurs in the fall and spring, individual screening is scheduled by appointment at other times of the year. Children with very obvious needs do not necessarily go through screening prior to assessment by the Program B team. This is a case by case determination.

Intake conference. Following the PSS evaluation (if warranted), the entire team decides which areas need to be screened and assessed. This decision is based on the information collected during the home visit, PSS results, and any other available information. Once again, children are screened or superficially evaluated in those areas that do not appear to be impaired or delayed. There do not seem to be established criteria for determining which developmental areas warrant a complete assessment for a given referred child. However, an unwritten understanding of when to screen and when to assess is evidenced by the staff's ability to reach quick consensus on this issue.

Participants in the intake conference include speech pathologists, classroom teachers, social workers, and the occupational therapist. Meetings occur on Wednesdays between 11:45 and 12:45. During the 1985-86 school year, 37 new intakes were completed. Of these, 14 subsequently were placed in Program B. Information on the service outcomes for children screened by Program B during 1982-83, 1983-84, and 1984-85 are presented in Table B-3.

Some of the information available at the time of the intake conference and shared among the team professionals included the following:

Portion of PSS screening that was failed
Child's activity level at home
Interaction style between parent and child
Possible physical abuse
Specific parent concerns
Parents ability to set limits/control child in the home environment
Parent languge structure (as possible causal factor in child's speech difficulty)
Child's level of separation anxiety
Child's behavior in a day care setting
Developmental milestones
Recent crises in the family (i.e., relocation, divorce)
Child's medical history

The information available on a particular child at the time of intake varies greatly and is related to the specific referral concerns. For instance, information on parental speech patterns is more relevant for youngsters with possible communication delays than for those with gross motor difficulties.

Screening process. All referred children are seen individually by one or more professionals for a one or two hour screening session. The one-hour screening occurs in the fall and spring during Program B's regular schedule. Children referred at other times of the year may be seen for a two-hour time period. Most referred children are screened in the area of communication. Language samples and voice recordings commonly are used during the one-hour assessment. Also, behavior observations are a critical element of the screening process. An observational record of a one-hour screening session and a screening report form are provided in Appendices B-2 and B-3.

Table B-3

Outcomes for Children Screened by Program B During Three School Years

Outcome	1982-83		1983-84		1984-85	
	N	%[a]	N	%[b]	N	%[c]
No Service	5	10	25	38	8	16
Service Provided by Program B	39	80	38	59	40	80
Service Elsewhere	5	10	2	3	2	4

[a] Percentage is of the total of 49 children screened/assessed.
[b] Percentage is of the total of 65 children screened/assessed.
[c] Percentage is of the total of 50 children screened/assessed.

Table B-4

Diagnostic Assessment Tools

Burks Behavior Rating Scales

Communication-Articulation Assessment Document

Goldman-Fristoe Test of Articulation

Language Sample Analysis

Phonetic Transcriptions

Fisher Logeman Test of Articulation Competence

Intelligibility Ratings by Speech Therapist

Diagnostic speech therapy

Behavioral Observation in all settings (play, story, snack, testing, arrival time, departure time)

Battelle

Sequenced Inventory of Communication Development (SICP)

Expressive One Word Vocabulary Test

Vulpe Assessment Battery

Oral Mechanism Exam

Kaufman Assessment Battery for Children (administered by psychologist)

Assessment to Placement

Areas of suspected need are assessed more thoroughly using a combination of the testing instruments and techniques shown in Table B-4. Teachers are assigned areas to assess on the basis of their particular areas of expertise. For instance, one teacher also functions as a half-time speech pathologist, and therefore assumes some of the responsibility for carrying out speech assessments. Other areas that are assessed include cognitive, social-emotional and behavioral, gross motor, and fine motor.

About 75% of the youngsters who have been screened are observed in the classroom setting for two weeks. Children excluded from the two-week classroom session are those "screened out" because they are developing normally or are experiencing age appropriate articulation difficulties. This past year, a larger number of 3-year-old children were screened. They were not placed in a diagnostic classroom because all 3-year-olds found to need service will be sent to a private special education school in the area (at district and county expense). There is not sufficient staff or space in Program B to effectively serve this population next year.

Referred youngsters attend the diagnostic classroom for eight days, 2½ hours per day. Two teachers, two speech pathologists, one aide, and a social worker are assigned to a class of 12 children. Approximately 1½ hours are spent observing and interacting with the children in open play. Near the end of the play session, the staff intervenes using various strategies to determine how the children respond to structure, teacher cues, and behavior management techniques. For example, a staff member might verbally model sharing behavior and record the student's response.

Twenty minutes are spent in structured group activities, including songs, finger plays, and "feely meely" bags. This is followed by a 15-minute snack period and a second half-hour structured activity session. The second session focuses on fine and gross motor activities as well as sensory experiences.

During the morning or afternoon session, children are pulled out for individual assessment in one or more areas. Speech pathologists will often do a more complete language assessment to supplement the data collected during the one-hour screening. About half of the youngsters are assessed in the cognitive area using the Battelle Developmental Inventory. An occupational therapist may individually assess gross motor development using the Miller Motor Scale or Peabody Developmental Motor Scale. Fine motor assessment is usually carried out within the classroom. A nurse may be asked to screen or rescreen hearing at this time.

Occasionally, youngsters are placed on an extended assessment (up to six weeks). This may happen for two basic reasons. First, children may exhibit subtle behavioral difficulties that require a longer diagnostic period to identify. Second, parents or nursery school teachers may have observed low frequency but significant problems that do not surface during the initial two-week period.

Many diagnostic classroom sessions that were extended from two weeks to six weeks failed to result in increased placements. Yet, when a child is referred for an emotional/behavioral assessment, there is an uneasiness among staff about making a decision within two weeks. The director questioned the utility of the extended assessment if results turn out similarly regardless of the length of the session. There was general consensus among staff to analyze how judgments are made and to determine when, if ever, a six week evaluation is necessary.

The assessment process varies somewhat if 5-year-old children who have not been previously served by Program B are referred. The problem is one of "turf." Is the elementary school or the early childhood program primarily responsible for assessing youngsters of kindergarten age? A case by case determination usually is made.

Precompilation Conference

Following the two-week diagnostic period, a precompilation conference is held. The Program B team, consisting of eight personnel (preschool coordinator, 2 classroom teachers, social worker, 2 speech/language pathologists, occupational therapist, classroom aide), meet to discuss the results, decide upon handicapping conditions, and make recommendations. Parents are not included in this initial conference. Approximately 5 to 10 minutes are spent discussing each case. In this way, 18 cases can be discussed within one 2½ to 3 hour meeting. The discussion takes place around a long rectangular table in which all professionals are able to maintain visual contact with each other. The preschool coordinator is seated along one side of the table between two staff members. An unfamiliar observer would be unable to identify the status of the professionals in terms of their self-selected seating arrangement.

The atmosphere during the observed precompilation conferences was one of casual professionalism. The staff displayed concern for each child and relied on test data and their own judgment for decision-making purposes. Discussion of new intakes always included a discussion of each child's strengths and weaknesses and a listing of recommendations. Recommendations made at the precompilation conference might consist of any of the following:

1. Placement in Program B
2. No service
3. Family counseling
4. Referral to Child Protective Services
5. Parent encouraged to join a parent support group
6. Regular nursery school placement or day care
7. Half-day early childhood/half-day "regular" nursery school
8. Private therapy
9. Contract for highly specialized services, such as a specific autism program

Occasional joking reflected a high level of comradeship within the group. However, comaraderie did not always mean consensus. Individual teachers and therapists felt at ease in stating their opinions, even when these were in conflict with the decision made by the coordinator. Consideration was paid to the suggestions made by all and the coordinator was comfortable with backing down on her previous position if effectively convinced. However, during approximately nine hours of observed meetings, there were only a few instances when more than three or four minutes was necessary to hash out an issue. Most of the time, the staff was able to discuss differences of opinion and reach a consensus that was comfortable for all. If a difference of opinion remains, the staff informs parents and often leaves the final decision up to them.

Compilation Conference

The next step consists of compilation meetings which are held on two days following spring and fall screening. At these meetings, test results and recommendations are shared with parents. The staff describes the assessment process and the child's strengths and weaknesses. To avoid a negative focus, the summary of findings always begins with a description of the child's positive attributes. Parents always are asked whether the staff's description of the child is consistent with what they see at home. Parents either are offered service or told why their child is not eligible. Alternative options to ECSE service, if appropriate, are discussed. Nursery school is a frequent recommendation made to parents. Occasionally, if stress in the home appears to be affecting a child's behavior, the family is encouraged to seek family counseling. At the conclusion of the meeting, a transitional Individualized Educational Plan (IEP) is implemented. After one month, the final IEP is completed and an IEP conference held.

Parents do not have to accept the team's recommendations. The team also is flexible regarding their recommendations. For instance, if parents want a three-day program instead of a four-day program because their youngster is in nursery school, the staff usually will go along with this modification.

Staff members expressed concern about how much information to impart to parents at this conference. Parents may be highly anxious and find it difficult to absorb a great deal of data concerning their child.

Another area of concern is related to Level II monitoring. Many children show mild delays, and could benefit from close monitoring. However, a Level II placement still results in the child being labeled as handicapped. Consequently, Level II service infrequently is offered to parents.

At the request of the coordinator, compilation conferences were not observed. This decision was based on the belief that initial diagnosis is a sensitive time for parents, and thus not an appropriate time to allow observation. Information in this report is based on interview data and written documents.

Assessment Report

An assessment report is completed on every child who is referred, except those "screened out." Children screened out are those briefly assessed and determined not to have a primary handicap. The assessment report contains the following information: (a) summary of relevant findings, (b) recommendations (no service, or type and level of service), (c) communication evaluation, including sources of information used to evaluate a given area, (d) evaluation summaries of all other areas assessed, and (e) social work report. An example of the assessment report form used is provided in Appendix B-4.

Much attention is given to the wording of areas of need and handicapping conditions in the assessment report. The director emphasized that reports should be carefully written so children are not inadvertently labeled as handicapped in areas in which they are not handicapped. Often it is recommended that general behavioral descriptions be used in place of category labels. Professionals on the team have the right to take issue with wordings with which they feel uncomfortable.

Assessment Time Frame

The assessment procedure is completed within 30 school days, in compliance with state law. Only days on which classes are in session are counted as school days (four days per week). In some cases, this procedure for counting days could result in children potentially waiting almost two months for completion of the assessment procedure.

Eligibility Criteria

Four-year-olds. For a four-year-old child to be eligible for Level IV service in Program B, the following criteria must be met.

1. Existence of disability (i.e., approximately 25% delayed or significantly deviant in one area of development)
2. Disability significantly affects educational performance
3. Disability is chronic rather than situational
4. Poor prognosis for change without intervention
5. Significant impact of family on disability and prognosis (i.e., a child may be eligible with less than a 25% delay in school performance; this would be a team decision on a case by case basis)
6. Two documented assessment measures on each confirmed disability

Three- and Five-year-olds. There must be either (a) two educationally-significant assessed handicaps, or (b) one educational handicap and one area of need. The handicap must be in either communication, emotional/behavior disorders, other health impaired, hearing impaired, physically handicapped, learning disabled, or (in rare cases) developmental delay. Motor alone is not an educational handicap, although it may be the basis for a "other health impaired" or "learning disabled" diagnosis.

Until this year, Program B required that a 5-year-old child be handicapped in two areas to qualify for service. The second criterion of one handicap and one need was added as an option because the staff found a requirement of two handicaps too stringent. Many youngsters were delayed in more than one area but did not quite meet program criteria to qualify as handicapped. The option to use one handicap and one area of need has ameliorated this problem, but also has resulted in a great increase in the number of 4-year-olds eligible to remain in Program B for an additional year.

The definition of "need" is not clear. The term appears to refer to an area in which the child is performing below average, but does not score low enough (1½ standard deviations below the mean) to qualify as handicapped.

A specific outline of other considerations and the procedures in determining eligibility for 5-year-old children is provided in Appendix B-5.

Issues of eligibility. One problem faced by Program B staff during the precompilation meetings was how to make decisions on youngsters with borderline scores. The general policy was to supplement standardized tests with other measures such as observations, language samples, or the Brigance. If performances on standardized measures and on other measures were both in the borderline range, the team found it difficult to rationalize special services for these children.

The category of Other Health Impaired (OHI) has presented problems due to the lack of clear-cut criteria. In the past, Program B relied heavily on input from the nurse and the occupatinal therapist more than on outside medical opinions. In a March memo to the staff from the program director, "Significant and pervasive motor delays (one year or more) accompanied by general low strength and chronic ear infections" was given as the basis for one such OHI label. The staff consensus was that a case by case determination be made on OHI eligibility using this type of input. In addition, the team would (a) document the rationale for the label clearly in the report, (b) obtain and document health history information when it could be a contributing factor, and (c) obtain existing medical reports when possible. Issues generated within the memo were the following:

(1) Who would be designated to offer health related services at the elementary school level?

(2) When multiple handicaps exist, can OHI be a primary handicap? Can it be the only label?

In terms of eligibility criteria, Program B adopts a more lenient policy for children with articulation disorders than does the state. Program B serves children who have articulation problems listed as a primary handicap in the Level IV classroom; the state does not encourage providing Level IV services to this population. However, Program B staff is appropriately cautious about providing service in cases where time to develop and mature may eliminate the problem.

Finally, the early childhood learning disabilities category is used rarely since it is difficult to document discrepancies between abilities and performance in this age group. According to one teacher, only one child has been classified as learning disabled in three years.

Intervention

Program B has four early childhood classes (two morning, two afternoon), with approximately 6 to 8 students in each class. Each class is staffed by a qualified teacher and a speech pathologist or an aide. The speech pathologist and the aide rotate, so that at all times there are at least two staff members working in each room. The speech pathologist may help conduct large group language activities or work with students on an individual basis.

The students in Program B attend school four half-days (approximately 2 hours per day) per week. The fifth day, Friday, is designated for team meetings and assessments. The daily programming is similar in each classroom. A typical schedule is shown in Table B-5. Morning and afternoon sessions are similar in format and organization.

Within the general format and organization, teachers do adapt to individual student needs. For instance, a child with poor interaction skills or a youngster who needs to learn sharing behaviors may be asked to choose a playmate before being given a preferred toy. Within a larger group setting some children exhibiting inappropriate behaviors were ignored, others redirected. Instructional materials and teaching strategies also varied with the needs of the child. Generally, it appeared that the child's IEP was the overall guide, but professional judgment determined day-to-day curricular and behavioral strategies.

As a formal part of the educational process, an IEP is developed for each child. Final IEP's usually are completed 6 to 8 weeks after the compilation conference. A question raised by the program coordinator was whether IEP's could be delayed if further assessment seemed necessary to determine a child's specific educational needs. If a child is referred midyear, the IEP may be completed at the time of the compilation conference. Teachers prepare the goals prior to sharing them with parents. Occasionally (not consistently), a sheet will be sent to parents prior to the conference in which parents are invited to share in the formulation of IEP goals. Although a few parents have participated, this process has not met with great success. It is a difficult time for parents and many are too unfamiliar with the process to feel comfortable formulating their own objectives.

Two IEP's were selected randomly from the Program B file in order to get a general idea of the types of goals and intervention strategies listed. Goals included in the two IEP's were:

Develop age appropriate interaction skills
Increase ability to attend and follow directions
Increase ability to effectively use play materials for exploration
  and learning
Improve fine motor skills

Table B-5

Typical Daily Schedule in Program B

9:15	Hello/Opening - Songs, name recognition games, conversation sharing, and "news" items
10:00	Work/Choice - Children work individually or in small groups on tasks that address their individual educational goals. Opportunities for play are provided regularly with the realization that many childen use play as the major medium for learning.
10:15	Snack - Objectives of snack time are to promote communication use and interaction.
10:30	Gym - Children participate in gym activities each day. The focus is on activities that develop large motor/movement skills, and opportunities for children to interact with each other, and exposure to a variety of equipment.
11:00	Closing - During the last part of the day children are encouraged to discuss the happenings of the day as well as their feelings. Musical activities and stories frequently are incorporated into this time.

Increase understanding of a variety of concepts
Increase the ability to cross the midline of the body
Improve scissor cutting skills
Improve the ability to go left to right (when drawing)
Improve tracking skills
Improve motor control
Improve gross motor skills
Improve abdominal muscle strength
Improve balance skills
Improve motor planning
Improve expressive language skills
The student will move from a passive response towards verbal and nonverbal assertion of self
Increase vestibular processing system and upper body strength
Improve motor imitation skills

Considerable variability existed in the lengths of the IEP's; one was 11 pages and the other was 5 pages. Several sub-objectives stated in behavioral terms were listed under each major goal. Criteria were stated in terms of proportion of trials needed for success or percentage of correct responses. Anticipated dates of completion were listed for each objective. In almost all cases, May was the given date of completion. One staff member was assigned responsibility for teaching a specific objective; however, neither specific teaching strategies nor instructional materials were included on the IEP form. Student mastery or nonmastery of objectives was generally (about 90% of the time) evaluated in April. If an objective was mastered, the word "met" and the date is listed under the column heading "Outcomes" on the IEP. If an objective had not been met, a more thorough description of the child's present performance was given in the problem area. Based on this small sample of IEP forms, it did not appear as though goals or objectives often are altered or evaluated midyear. However, through observation of team meetings and informal interactions, it is evident that the staff does consult with each other and make programming changes when needed.

Team meetings provided a good environment for initiating changes in intervention strategies. One of the broadest changes proposed in this area was to include "typical" or normal functioning children in the program to serve as peer models. Intervention recommendations also were discussed at the time placement decisions were being made. A great deal of emphasis was placed on describing optimal teaching strategies for fostering the child's learning.

In sum, intervention strategies and subsequent changes were shaped broadly by the IEP. IEP designated strategies then were implemented or changed as a result of the professional judgment of an individual teacher or therapist, or through consensus of a team of professionals.

Exit and Follow-up

Transitional Conferences and Staffings

A series of meetings is scheduled each spring in order to evaluate student progress and to determine future placement. In early April, transition staffings are held in which the entire Program B staff reviews student progress according to IEP goals and discusses needs for the subsequent school year. A partial transcript of a transition staffing is included in Appendix B-6; it illustrates the decision-making process involved in making transition decisions.

In mid-April, a conference is held with the staff and the parents. At this meeting, student progress and recommendations for the upcoming school year are reviewed. Occasionally, parent requests at this point differ from staff recommendations, especially in terms of kindergarten placement. If parents strongly desire that their children enter kindergarten instead of being served in Program B an additional year, their desires are honored.

A third meeting, the Child Study Team meeting, focuses on the children who are designated as "graduates" of Program B: those who will enter a regular elementary school in the fall. Two representatives from Program B go to the child's future school and meet with the special education coordinator and designated teachers. Both special education and regular education teachers are involved in this meeting if appropriate. The professionals from Program B share information on children's strengths, need areas, and effective teaching strategies. In addition, a recommendation is made regarding the level of service for the next year. An average of 30 children are transitioned from Program B to one of six elementary schools each year. The meeting is brief. Approximately 45 minutes is spent discussing the needs of five to six children (about 10 minutes per child).

At a subsequent meeting at the Program B building, usually in mid or late May, the parents are introduced to the case manager and the support person from the child's future school. The child's needs are discussed informally. Also, at this time a partial IEP is written for fall. In May each child's file is delivered to the appropriate school in person by the Program B secretary.

Summary of first transition conference. Although an average of 5 to 7 minutes is spent discussing each child, there is considerable time variability from one case to the next. Recommendations are decided immediately for some children, with little or no discussion needed. Other cases are more complex or confounded with other issues. Some of these issues are discussed here.

Determination of handicapping condition and subsequent placement is more difficult for 5-year-olds because the elementary and early childhood labels are not always comparable. For example, a child with an Early Childhood Special Education label cannot receive services in regular kindergarten unless he or she is re-assessed and relabeled.

The greatest controversy arose over the issue of whether Program B or the elementary school's child study team should terminate a child's special education services. Some of the Program B staff thought that this exit decision should be the responsibility of Program B staff, if the label is no longer appropriate. Others believed that it would be more judicious to wait and see how the child adjusts to the new environment. For example, if a child with an EBD label adapts well to the new school and presents no problems, the label can be removed at that time.

A retrospective study completed by Program B suggested that the majority of program graduates labeled as having emotional or behavioral difficulties did not retain this classification in elementary school. Problems in transition occurred when Program B reported disordered behavior that the regular education staff in the elementary school did not see. Therefore, as part of the transition process, the coordinator believed that there must be more information to foster awareness that children might be expected to improve because of developmental change and/or early intervention success.

Reluctance on the part of the staff was expressed in recommending a Level IV self-contained program to parents three months before the new school year. The concern was precipitated by a conference at which the coordinator was told that a child for whom Level IV had been recommended was doing well in the mainstream. It was decided that this issue would be brought up at the next parent meeting. Occasionally, the dilemma centered on whether to recommend a Level IV program for 5 year olds or to allow them to remain in the Program B for another year. A rule of thumb to be used is as follows:

> If kindergarten is clearly inappropriate for a 5 year old, the Level IV elementary handicapped program will be considered. A child who is likely to need a Level IV program for more than one year (i.e., as a 6 year old) should be referred to the elementary school as a 5 year old. Also, the Level IV elementary program should be considered for children who are more deviant than delayed.
>
> Five-year-olds eligible for Level IV may receive Program B services if they probably will be ready for kindergarten or can be placed in the mainstream during the following year.

These guidelines are based mainly on professional judgment.

Occasionally, decisions on future placement are guided by the staff's knowledge of elementary or private school teachers' personalities. They expressed reluctance in placing a very sensitive child in a classroom with a "high-strung" teacher. However, anticipated teacher-student interactions was an infrequent placement criterion.

Overall, it was evident during the transition conference, that the staff was well prepared and had a good knowledge of student strengths and weaknesses. No pre-established exit criteria were used to make placement determinations. In practice, many factors entered into each decision. These included:

child's age
type of handicap
specific needs
effective teaching strategies

degree of academic growth
degree of behavioral change
predicted future performance
parent requests
availability of other options (i.e., nursery school, private school)
length of school day child can handle

No one factor consistently had priority over the other factors. Each case was decided individually, with the needs of each youngster carefully considered. However, if parents were very strongly opposed to a team decision, their requests usually are honored. Of the decisions made regarding the 35 children discussed at the transition conference, changes were made in only three cases. In two cases, the staff had second thoughts and altered their recommendation prior to meeting with the parents. In the third case, a recommendation was made to retain a child in the Program B an additional year. The parents said no, feeling that their son was too large physically to look appropriate in an early childhood setting. The staff went along with their decision, agreeing that placement in a regular kindergarten was worth a try.

Approximately 9 to 10 5-year-olds of the 35 children discussed at the transition conference will remain in Program B an additional year. This contrasts with the 4 to 5 children retained in the previous year. The revision of eligibility criteria for 5-year-olds partially accounts for this increase.

General transition trends. Approximately 10% to 15% of the 5-year-olds served in Program B are retained for an additional year. This figure increased dramatically during the 1986 transition because of the change in eligibility criteria for 5-year-olds. Documentation of one handicap and one area of need instead of two handicaps has made it easier for Program B to serve 5-year-olds an additional year.

One difficulty in making transition decisions is that there is no special education alternative to kindergarten in District B. One school in the district offers a Level IV program for EMR children and children with severe communication or behavioral disorders. More mildly handicapped children are frequently placed in a regular education kindergarten with supplemental speech therapy or counseling services depending on the need. Children occasionally are exited from special education before they reach kindergarten age. If this is the case, nursery school is often recommended to parents.

Follow-Up Procedures

In the fall, elementary school teachers are contacted and a schedule set up to visit their classrooms to observe how recent Program B graduates are faring. The procedure is as follows:

1st week - Informal notes on each child are sent to teachers

Table B-6

Number of Children Served in Program B During Three School Years

Primary Handicap in Program B	1982-83		1983-84		1984-85	
	N	%	N	%	N	%
Communication	24	62	25	66	13	33
Emotional/Behavioral	12	31	6	16	16	41
Other Health Impaired	2	5	3	8	7	18
Developmental Delay	1	2	2	5	1	2
Motor Impaired	--	--	--	--	--	--
Learning Disabled	--	--	--	--	--	--
Hearing Impaired	--	--	2	5	--	--

Table B-7

Consistency of Classifications Between Early Childhood and Elementary School

Primary Handicap in Program B	1982-83		1983-84		1984-85	
	N	%	N	%	N	%
Communication	6	25	5	26	5	50
Emotional/Behavioral	1	8	0	0	3	27
Other Health Impaired	2	100	1	50	3	43
Mentally Retarded	1	100	2	100	--	--
Motor Impaired	--	--	0	0	--	--
Learning Disabled	--	--	--	--	--	--
Adaptive Physical Education	--	--	--	--	--	--
Repeat Early Childhood Special Education	--	--	--	--	--	--
Kindergarten - No Special Service	--	--	--	--	--	--

2nd week - Program B coordinator calls kindergarten teachers to set up a classroom visitation

3rd - 4th weeks - A Program B staff member visits each class to observe the "graduates" and offer support to the kindergarten teacher

As needed - Program B staff is available to participate in elementary team meetings about "graduates"

No formal routine has been established to follow up on Program B graduates after the first month of school. As noted earlier, the Program B coordinator did conduct a longitudinal study of students who had exited from Program B in the years 1978-1981. The study was designed to gather information on the type of services received in elementary school by Program B graduates, to determine the long-term prognosis for this population, and to assess trends. The school district computer and child study secretaries were used to track down the histories of special education services for students who left Program B. The following general findings were obtained:

- Only 1 of 8 children assessed ED in Program B retained the label in elementary school. The rest moved, were reassessed as LD, were served with Speech as their only handicap, were terminated, or changed to some other handicap.
- About one-half of the graduates continued to require some level of service in elementary school. The other half moved or no longer were provided special education services.

As part of the present analysis of Program B, children who exited in the years 1983-1985 were followed retrospectively. Data concerning the amount and type of special education service were available through a computer print out. However, children who are no longer receiving special education services are not listed on the print out. Therefore, it is not known whether special education services have been terminated for these youngsters, or they have moved to another school district. Because of this, data have been interpreted and analyzed in terms of general trends.

The primary handicaps of children served by Program B in each of three years are presented in Table B-6. (Note that totals in this table may exceed 100% because some children were served in more than one area.) In 1982-83 and 1983-84 most children were screened and referred for special education services in the area of communication. In 1984-85, a greater percentage were referred for social-emotional concerns. The program serves a few hearing impaired youngsters. The label of "developmentally disabled" is rarely applied to a preschool child. According to District B personnel, it is very rare that children are referred and serviced as learning disabled, and "motor impaired" is never considered a stand alone service.

The degree of consistency between the primary handicap serviced in early childhood special education and the area serviced in elementary school is shown in Table B-7. Clearly, consistency is a function of the type of handicap. Students serviced for problems in the area of developmental delay are almost always placed in elementary programs for the mentally retarded. Approximately ¼ - ½ of preschool youngsters receiving communication services subsequently receive speech-language services at the elementary level. From 43% to 100% of youngsters classified as "other health impaired" are similarly labeled and serviced 1 to 3 years later. Relatively few students with a primary emotional/behavioral handicap in preschool special education continue to be serviced in this area after leaving Program B.

A similar pattern exists with respect to the consistency between the recommendations made by Program B staff at preschool exit conferences and subsequent services offered to early childhood "graduates" at the elementary level (see Table B-8). Recommendations for continued communication services are followed in about 1/3 to 1/2 of the cases. Based on available information, a recommendation for EMR placement always results in subsequent placement in an EMR classroom. In contrast, less than 14% of the students serviced in the area of emotional/behavioral problems in 1982-83 are similarly classified in later school years. However, the percentage of consistency between an ED recommendation and later ED placement was much higher for the 1984-85 student.

Some important points should be considered when interpreting these tables. First, in some cases, children not listed on the special education printout might be receiving special services in another district. Therefore, numbers and percentages may underestimate the actual statistics. Second, the number of youngsters within each handicapping category is extremely variable, confounding strict interpretation of percentages. For example, in 1982-83 only one recommendation was made for EMR programming at the elementary level, resulting in subsequent EMR services for that child. Thus, the figure "100% consistency between recommendation and future service" is based on a single case. Despite these difficulties, the data from three consecutive years show a great deal of consistency, suggesting some degree of data reliability.

To examine Program B's predictive accuracy, a check was made on the youngsters screened between 1982-85, but offered no service. From 10% to 38% of children screened were not found in need of preschool special education services. As shown in Table B-9, none of the children who were refused preschool services is currently receiving special education services in this district! About 1/4 to 1/3 of those screened and offered service continue to receive special education in elementary school. Thus, data suggest that Program B is doing an effective job in identifying youngsters who will succeed educationally without early intervention as well as identifying a good proportion of children who continue to need supportive services in elementary school.

Summary

This school district offers a comprehensive, well-planned out screening and intervention program for pre-kindergarten youngsters. A great deal of effort and interdisciplinary cooperation was evident throughout all stages of the screening, assessment, and intervention process. The overall yearly procedures, from the initial stages through follow-up, as summarized by the Program, are shown in Appendix B-7.

Table B-8

Consistency Between Early Childhood Exit Recommendations and Present Service in Elementary School

Recommended Area of Service	1982-83		1983-84		1984-85	
	N	%	N	%	N	%
Communication	14	33	4	57	2	29
Emotional/Behavioral	1	14	--	--	3	43
Other Health Impaired	--	--	--	--	--	--
Mentally Retarded	1	100	2	100	1	100
Motor Impaired	--	--	--	--	--	--
Learning Disabled	--	--	--	--	--	--
Adaptive Physical Education	--	--	--	--	--	--
Repeat Early Childhood Special Education	3	60	--	--	4	50
Kindergarten - No Special Service	--	--	--	--	--	--

Table B-9

Percentages of Children with Different Screening Outcomes Who Later Received Elementary Special Education Services

	% Currently Receiving Special Education		
Screening Outcome	1982-83	1983-84	1984-85
No Service Offered	0	0	0
Service Offered and Provided	33	24	31

Chapter 4: Program C

Camilla A. Lehr

Program C is an early childhood special education program that began in 1976. It currently has two components: one serves children ages 4 to 5 years (Component C-1) and the other serves children who are somewhat older and slightly higher functioning, and who are considered ready to be mainstreamed into kindergarten (Component C-2). During 1985-86, the two components were located in separate buildings. Figure C-1 is a schematic presentation of the two components of Program C, and their relationship to the screening, assessment, and decision-making process within School District C. An overview of the numbers of children at various steps of the process is provided in Table C-1.

Program Description

Community Characteristics

District C is located within 20 miles of a large metropolitan area. It encompasses all, or parts of, seven communities that range in population size from 410 to 22,680 (Metropolitan Council, 1985). The early childhood special education program is located within the largest suburban community of the district. During the past five years, all District C communities have increased in size. General characteristics of the communities are summarized in Table C-2.

The surrounding communities are tight-knit, and the district takes pride in developing and maintaining quality education. One relevant piece of evidence for this claim is that for the past nine years the district has received state funds for a pilot Early Childhood Family Education program. Educational awareness of this program in the community is quite high, and the district tries to encourage community participation by providing information in a community newspaper, and by distributing flyers developed by the Early Childhood Family Education program. Although the special education program is distinctly separate from the Early Childhood Family Education program, it undoubtedly is influenced by its presence.

An open-ended questionnaire sent to Program C parents as a part of this study (70% return rate) reflected considerable support for the district and its special education programs. Parents' responses indicated that they felt that the school district places value on meeting the individual needs of their children. In addition, some parents suggested that a belief in and support for early detection and intervention is reflected in the quality of services provided.

History/Rationale/Philosophy

In its first year (1976), Program C served eight children 4- to 5-years-old. The program has expanded over time; it served 42 children during the 1985-86 school year. The program was divided into two classrooms in 1983

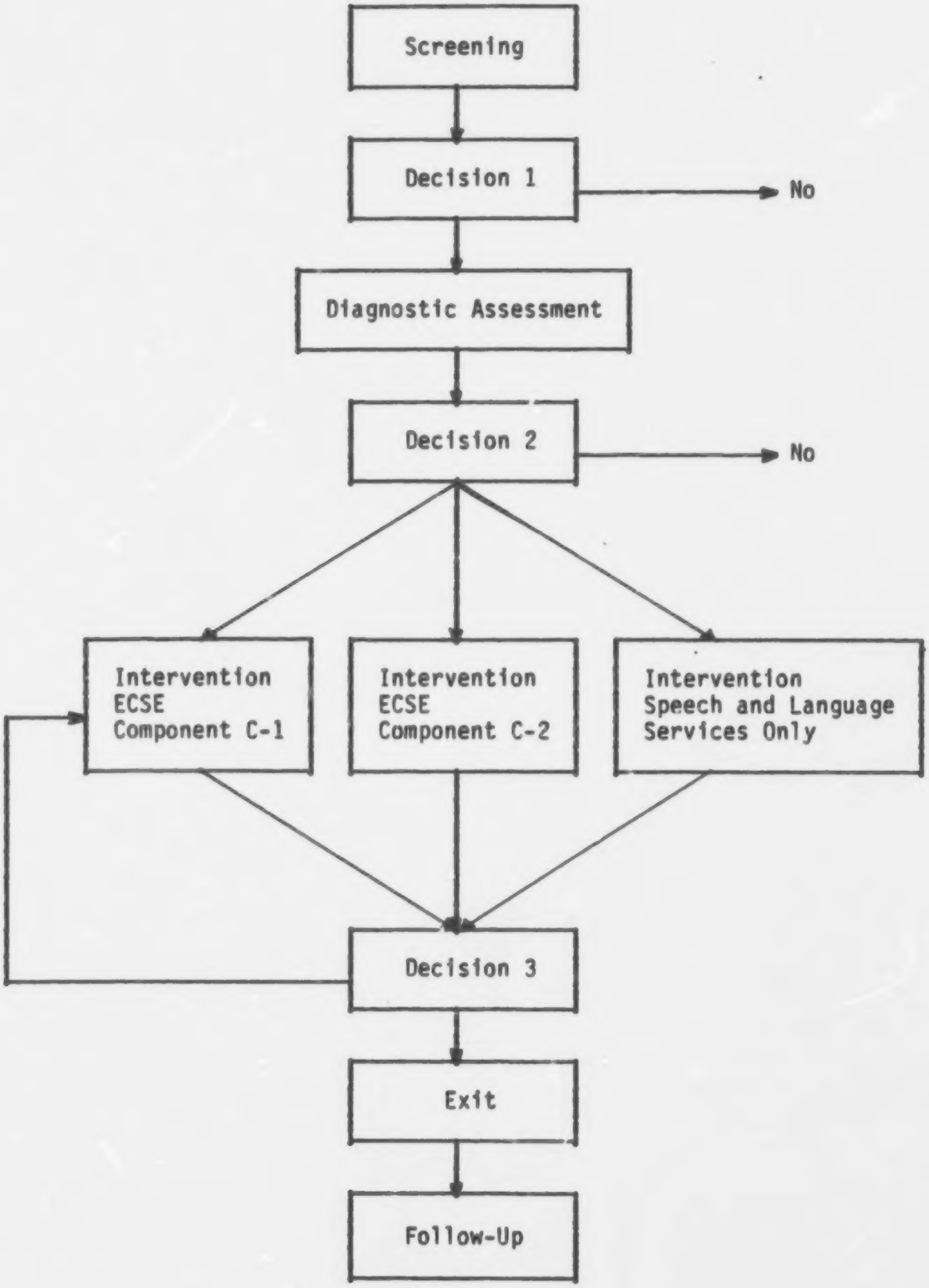
Screening
Decision 1
No
Diagnostic Assessment
Decision 2
No
Intervention ECSE Component C-1
Intervention ECSE Component C-2
Intervention Speech and Language Services Only
Decision 3
Exit
Follow-Up

Figure C-1. Major stages and decision points in Program C's early special education assessment and decision making process.

Table C-1

Number of Children Entering Program C (1986-87)
(Process From Screening to Entrance)

Number Eligible for Screening	1,050[a]
Number Screened	597
Number Pulled for Team Review	47
Total Number Given Diagnostic Assessment	29
Number Referred from Preschool Screening	19
Number Referred from Other Sources (e.g., parent, hospital, developmental achievement center)	10[b]
Total Number of Children Entering Program C	14
Number Entering Component C-1	9
Number Entering Component C-2	5
Total Number of Children Qualifying for Speech and Language Only	6
Total Number of Children Qualifying for Adaptive Physical Education Only	1

[a] Approximation from Census Information

[b] May also have gone through PSS, but original referral was from another source

Table C-2

Demographic Characteristics -- 1980 Census Data Metropolitan Council

		Comm 1 (Urban)	Comm 2 (Urban)[a]	Comm 3 (Urban)	Comm 4 (Urban)	Comm 5 (Urban Fringe)	Comm 6 (Urban)
Count of All Persons		394	2846	5111	22528	3771	1059
Persons by Gender (Female)		202	1421	2574	11502	1830	521
Persons by Gender (Male)		192	1425	2537	11026	1941	538
Count of Families		96	770	1367	5977	941	288
Single Female Household		8	24	144	597	43	15
Housing Units (Owner)		101	797	1339	5716	1000	301
Housing Units (Renter)		15	9	416	1405	77	22
Nursery School	3 years old and older enrolled in school	0	67	132	213	87	12
Grades K-8		66	489	680	3804	809	159
Grades 9-12		58	410	356	2094	326	114
College		12	144	209	1074	80	84
Median Income		22,143	53,285	22,050	25,080	22,963	33,691
Average Income		38,525	64,454	24,063	26,946	25,564	38,571
Households Receiving Public Assistance		0	0	50	247	29	13
Households Below Poverty Level		0	0	42	197	55	2
Percent Unemployed		21	3	8	8	13	8
Private	Employed Persons 16 Years and Over by Class	145	958	2315	8758	1347	390
Government		26	177	386	1962	200	130
Self-Employed		12	126	102	414	123	28
Median Gross Rent		$ 260	$ 0	$ 283	$ 264	$ 270	$ 284

[a] Approximately 1/3 of community is within district boundaries.

because a single setting could not accommodate the number of children who qualified for service. In addition, age, skill level, and handicaps varied extensively across children. Thus, two components were developed: one for children aged 4-5 (C-1), and the other geared for older children functioning at a slightly higher skill level who could be mainstreamed into kindergarten (C-2). Both components were located in a single elementary school for one year. But in 1985, they were forced to move to other locations because the enrollment of the elementary school increased and the space was needed for regular classrooms.

Administrative personnel, teachers, and specialists had similar perceptions of the goals of Program C. The primary aim of the program is to prepare children for mainstreaming. For Component C-1, mainstreaming into regular preschool programs or kindergarten was a desired outcome. This program is aimed at facilitating each child's total development, including cognitive skills, motor skills, social-emotional skills, etc. For Component C-2, the goal was for children to be mainstreamed into regular kindergarten classes or first grade classrooms. According to the lead teacher, a more specific goal of Component C-2 is to develop kindergarten readiness skills. Thus, it follows a curriculum focusing on pre-reading skills, number skills, social skills, etc. Staff in both components stated that greater parent involvement and increasing parents' understanding of the program and their child's needs was a goal toward which they were working. These program goals were not documented in writing.

Both program components received referrals and incorporated new children into their classrooms throughout the year. The staff believes that the children who require service are indeed being served. There were some questions as to whether children were receiving enough of a particular service (e.g., occupational therapy) and whether the children were being served in the most appropriate setting, specifically geared to their needs. For example, in Component C-1, the division of children into morning and afternoon classes had to be dictated largely by busing considerations. Thus, the classes were not necessarily composed on the basis of skill level or primary problem area.

Physical Setting

Program C's two components were located in separate buildings, approximately two miles apart. They had been in their current settings for one academic year. It appeared that the staff of each component played a strong role in decisions about where each would be housed.

Component C-1. This component is for children 4 to 5 years of age whose needs cannot be met in a regular preschool or kindergarten setting. The staff of this component requested that it be located in the same building as the district's Early Childhood Family Education program to facilitate transition to a mainstream regular preschool setting. (Mainstreaming is a primary goal of the program.) The Early Childhood Family Education (ECFE) program offered a variety of classes and services for families of children between birth and the age of kindergarten enrollment. Component C-1 and the ECFE program were located in the same wing of a former junior high school. For the past five years, district administrative offices replaced classrooms in this building. Offices in the building included, for example, those of the superintendent (elementary, secondary, assistant), media center, and special education administrators.

Component C-1 staff recognize several advantages and limitations of being in their current location. Foremost was the advantage of being adjacent to the regular early childhood program. This facilitated transition into the mainstream by maintaining a consistent building environment for the young children. In addition, the rooms that Component C-1 specialists used for occupational therapy and speech therapy were located next to the classroom, allowing easy access and more flexible time schedules with the children. However, the staff perceived that because the building is not a regular elementary school with a central supply room, it was more difficult to obtain supplies and materials for the classroom. The building does not have library facilities for the children or staff to use for story time or to obtain resources. Further, Component C-1 staff members were relatively isolated from teaching staff typically found in an elementary school program. This isolation made it difficult to keep up with the latest information disseminated by the district in regular school settings. Although housed with ECFE staff, the programs are technically separate entities and function independently of one another, often precluding extensive interaction among staff members. Being located near the special education administrators' offices was cited as an advantage because it allowed easy accessibility to them. However, staff also noted that it is sometimes difficult to know who to report to in a building without a principal.

Component C-1 had access to three large classrooms. The main classroom had two tables with chairs; one was "U" shaped and generally designated for snacks; the other retangular table typically was designated for activities (e.g., coloring, pasting, etc.). Approximately half of the floor was carpeted and lining the wall were shelves that held books, blocks, and miscellaneous toys in an organized fashion. The children's names and birthdates lined one wall, and other walls were covered with projects created by the children. Other objects in the room included a sink and counter area, puppet theatre, playhouse furniture (e.g., stove, sink), an easel with a calendar, etc. In general, the room resembled a regular preschool room geared for children aged 4 to 5 years. Another large classroom was used exclusively by the occupational therapist (OT) and speech therapist. The OT also had access to a gym. The OT classroom had several objects in it, including a climber (covered when not in use), tunnel, rollers, incline ramps, etc. The classroom used for speech therapy also functioned as an office for Component C-1 teachers and a school nurse. The speech therapist typically worked with children individually at a table or in a small area.

Responses obtained from an open-ended questionnaire sent as part of this study to Component C-1 parents (70% return rate) indicated that most parents were satisfied with the location of the program. Although some parents noted that the program was centrally located within the district, they also indicated concerns about long bus rides for their young children (up to 45 minutes). Other parents made favorable comments about the program's location within the same building as ECFE and commented on the appropriateness of the physical characteristics of the classroom (e.g., spaciousness, proximity to a bathroom, resemblance to regular preschool/kindergarten classroom).

Component C-2. Component C-2 was in a K-6 elementary school. The school served 471 children during the 1985-86 academic year, 96% of whom were caucasian

(4% minority: 4 Black, 4 Hispanic, 10 Asian, 1 American Indian). In addition to the regular classrooms, the school had two classrooms for children with behavior disorders: one for grades K-3 and one for grades 4-6. The school also housed a special education resource rooom for K-6 children, and a classroom for children with special learning disabilities.

According to the lead teacher of Component C-2, there were many advantages to being located within an elementary school building. The classroom was across from the two regular kindergarten classrooms. This allowed the children to be among peer models and facilitated the transition into regular kindergarten. In addition, the library was adjacent to the Component C-2 room, and a gym was across the hall. Thus, the children had access to regular features of an elementary school. Due to space limitations in this school, however, occupational therapy services and speech services were conducted in rooms that were not specifically designed for those purposes. The lead teacher did note that the principal of the building was very supportive of the C-2 program and was actively involved in child study staff meetings. However, the teacher also noted that she supervised the full-day students in Component C-2 during lunch, an "obligation" that may have been due to program model more than to physical setting.

The Component C-2 classroom had 16 desks for the children, as well as carpeted areas on which to sit. The room was somewhat larger than a regular classroom and was divided into several areas, including a sink and counter against the back wall, an area for hanging coats, a large area for gross motor activities, a back corner for the teacher's desk and a table for assessment, and the desk area. The curriculum focused on kindergarten readiness skills, as evidenced by bulletin boards with a calendar (month, year and day), concepts such as yesterday and today, number line, alphabet, and a mailbox for each child. In addition, there were shelves with materials (clocks, puzzles, blocks) along with a full length mirror, plants, and a record player.

Organization and Staff

Each component of Program C has a team that makes decisions about children in the program. Component C-1 staff included specialists (occupational therapist, school psychologist, speech and language clinician), two co-teachers, a management aide, and the special education coordinator. This team had worked together during the previous year, and seemed to work particularly well as a team during the year.

Interactions among team members occurred quite often informally, and formal staff meetings occurred about once per month. The special education coordinator of the early childhood program often visited the Component C-1 classroom and seemed to serve as spokesperson and advocate for the team. Information about the Component C-1 staff is included in Table C-3. All of Component C-1's staff members had at least two instances of additional training within the past year. Activities included attending workshops (on new testing techniques, early childhood skill development, INREAL training, behavior management), taking coursework, and participating in parent support groups.

Table C-3

Component C-1 Staff

Title	Years with Program	Qualifications
Co-Teacher	2	B.S. Special Education Certified in TMH, EMH and EC:SE 12 years EC:SE teacher
Co-Teacher	2	M.S. Communication Disabilities Licensed in speech and language Nearly completed EC:SE certification 10 years professional experience working with children 3-6; Special Education coordinator and supervisor in preschool and elementary settings
Management Aide	7	Volunteer at rehabilitation location 7 years of experience as a management aide
School Psychologist	1	Ph.D. Background in Counseling Professional experience in School Psychology and related fields
Occupational Therapist	2	B.S. in Occupational Therapy 6 years professional experience with young physically handicapped children
Speech and Language Clinician	3	B.A., M.A. Speech and Language Professional experience in multicategorical language program and clinical speech supervisor (University position)

Component C-2 operated as an entity separate from Component C-1. Most meetings took the form of a Child Study Team, which generally consisted of the building principal, the special education coordinator, the lead teacher, and various specialists (OT, speech and language clinician, school psychologist). Meetings were scheduled formally and contact between the lead teacher and the special education coordinator was less frequent than in Component C-1. According to the lead teacher, she worked closely with the specialists (e.g., OT, speech clinician, kindergarten teachers) who helped plan instructional programs, and with the school principal. Information on the Component C-2 staff is included in Table C-4.

Minimal contact occurred between the teachers of the two Program C components. It seems that placement in different buildings and some teacher preference helped to maintain the operation of the components as separate entities. The special education coordinator served as a liaison between the two components, which shared the services of one school psychologist, and various other specialists.

Staff members' requests for materials, questions on policy, and so on, typically went first to the special education coordinators, and then to the director of special education. Two special education coordinators were employed by District C: one was mainly responsible for the occupational therapists, speech/language clinicians and adaptive physical educators; the other was mainly responsible for the teaching staff of special education programs within the district and was designated as the early childhood program coordinator.

Funding

Funding sources for Program C were the same as those for other early childhood special education programs in the state. Exact budget figures for Program C were available from the special education director, but were not obtained for the purpose of this study.

The Early Special Education program is allotted specific amounts of money for materials at the beginning of the academic year. Requests for materials are generally passed from staff members to the special education coordinator and then to the special education director. Some questions regarding small amounts of money (e.g., snack budget) were handled within staff meetings attended by the special education coordinator.

Although budgetary breakdowns are considered an administrative task, some staff members were knowledgeable about the Preschool Incentive grant and they noted that it is strictly for "extra expenses" rather than for regular staff time or supplies. Staff also knew that funding levels were based on child count data.

Other Influences

Program changes. Both components of the early childhood special education program in District C have undergone changes in the number of children within

Table C-4

Component C-2 Staff

Title	Years with Program	Qualifications
Lead Teacher	2	Licensed as a K-6 teacher, EMH and ESE Experience with EMH children (19 years), Kindergarten children (15 years)
Management Aide	1	6½ years aide with junior high students with learning and behavior problems
Occupational Therapist	1	
Speech and Language Clinician	3	B.A., M.A. Speech and Language Professional experience in multicategorical language program and clinical speech supervisor (University position)
Vision Teacher	1	B.S. 60+ credits in Vision
School Psychologist	1	Ph.D. Background in Counseling Professional experience in School Psychology and related fields

their programs. Component C-1 served 21 children at the beginning of the academic year; the number increased to 25 by the year's end. Component C-2 initially served 14 children; that number increased to 17. State regulations dictate the student-to-teacher ratio for serving young handicapped children:

> Subpart 3. Case loads for early childhood program alternatives. The following table sets forth the maximum number of pupils that may be assigned to a teacher's case load for the early childhood program alternatives. "Case loads" means the number of pupils taught.
>
> Consultation and indirect services program - 24
>
> | | |
> |---|---|
> | Center-based program - Option 1 | |
> | Deaf/blind, autistic, or severely multiply handicapped | |
> | One class, with one aide | 4 |
> | One class, with two aides | 6 |
> | More than one class, with one aide | 8 |
> | More than one class, with two aides | 12 |
> | All other disabilities | |
> | One class, with one aide | 8 |
> | More than one class, with one aide | 16 |
>
> Center-based program - Option 2
> Early childhood team (one teacher, one related services staff member, one aide) - up to eight students per member, but not more than 16
>
> | | |
> |---|---|
> | Home-based program | 12 |

Because of the increase in students served in the C-1 Component, a change in the number and qualifications of staff was necessary. This change first was discussed informally by staff, with some reference to the state guidelines.

Because of concerns related to compliance with state regulations and in order to better manage and serve the children, the issue of student to teacher ratio was raised at a staff meeting composed of the lead teacher, speech clinician, occupational therapist, classroom aide, and special education coordinator. The lead teacher was the main spokesperson for the group and suggested alternative methods to remedy the situation. It was proposed that the Early Childhood team option be put into place. The speech clinician, who was already in the classroom for a significant amount of time during the day, would become a full time co-teacher. The speech clinician was enrolled in early childhood courses and was close to meeting certification requirements. In addition, because she was familiar with the children and was a speech/language clinician, it was felt that her qualifications would make her an asset to the classroom. The entire group supported this suggestion and the special education coordinator noted that she would bring it to the attention of the special education director. This reassignment made it necessary to hire a speech clinician to fill her position. The change was made and the new speech clinician began working individually with children in February.

The change in staff composition also resulted in a revised role and different duties for the speech clinician. Prior to the new hiring, part of the speech clinician's role was to work on language skills in the classroom with groups of children. This function was in addition to working individually with children on specific goals. The new speech clinician's duties included only individual work with children.

Another change that was anticipated to occur during the year was related to definitions of criteria for entrance into the program. By choice, the program's entrance criteria had not been the same as the state's suggested criteria. Criteria for entrance into an early childhood program as recommended by the state are listed in Table C-5. The issue was discussed at a team meeting that included lead teachers from both components, speech clinician, occupational therapist, school psychologist, and special education coordinator. The special education coordinator led the discussion and urged the people who were present to examine criteria previously used, state criteria, and proposed new criteria. For most areas (cognition, social-emotional development, motor, and speech), district criteria involved a 25% delay, while state criteria used standard deviations from the mean. The special education coordinator urged for consistency in defining criteria.

Another change that was desired by both components of Program C was increased contact with the home by means of home visits. Home visits had not been implemented on a regular basis, although some home visits were conducted in Component C-1 for assessment purposes, partly because of transportation difficulties (parent could not bring the child to school), and also to obtain information about the home environment. Home visits generally occurred during the day and lasted approximately two hours. The agenda varied and often included formal assessment, observation, or a parent interview. A substitute teacher was hired on occasion to take the place of the lead teacher for the day if she was involved in home visits. Car fare was reimbursed. Reasons for home visits not being consistently scheduled fell into four categories: (a) not enough time (e.g., took away from class time), (b) not enough money (e.g., for substitutes), (c) a belief by administration that time can be more valuably used, and (d) working parents precluding visits during the day.

State department influences. At the time of this study, several anticipated changes resulting from changes in state policy were influencing Program C activities. Recently, the state of Minnesota mandated special education services for 3-year-old children. It appeared that District C would contract for services with local agencies that have traditionally served 3-year-olds. The reason for this was two-fold. First, the funding for 3-year-old children would not be sufficient to provide for quality services, and subsequent services provided by the school would be less in quantity (amount of time available) than what other agencies had been providing. Second, due to time pressures, quality programs for three year olds could not be developed and implemented before the 1986-87 school year. Future servicing of 3 year olds in the district will change the program extensively (e.g., staffing, budgeting, curriculum, location). At the time this report was written, these changes were unspecified; however, an awareness of the impact of programming for 3-year-olds was evident.

Table C-5

State Criteria for Entrance Into ECSE

TERMINOLOGY

Early Childhood:Special Education (EC:SE)

DEFINITION

EC:SE shall be available to those children birth to seven years of age who need special instruction or services because they are visually, auditorially, physically or other health impaired; are emotionally/behaviorally disordered; have an identifiable syndrome known to hinder normal development; or have a significant delay or impairment in cognitive, speech or language development.

ENTRANCE CRITERIA

A child is eligible for EC:SE if s/he is between the ages of birth and seven years and the child's handicapping condition:

(1) meets the eligibility criteria of the following disability/program areas: Speech, Language, Hearing Impaired, Visually Handicapped, Mentally Handicapped, Emotionally/Behavior Disordered, Physically or Other Health Impaired, Autism, Deaf-Blind, Learning Disabilities, and Developmental and Adaptive Physical Education;

OR

(2) is manifest in a delay in cognitive or language development that is verified by an assessment using an appropriate, standardized norm-referenced instrument which shows the child to be functioning at least 1.5 standard deviation below the mean and supported by documented, systematic observation;

OR

(3) is an identifiable syndrome known to hinder normal development (i.e., Down's Syndrome).

A second concern emanating from the state department was related to the role of the occupational therapist (OT) in the service of young handicapped children. Minnesota has had an increase in occupational therapists employed by school districts within the past few years. The state was examining the funding expense of employing occupational therapists, especially in terms of the academic impact of their therapy on the educational development of children, and advocating limiting the use of occupational therapy to children who exhibited significant motor difficulties. The state also proposed that adaptive physical education teachers and consultation, rather than direct service, could fulfill some of the same functions that OT's typically did. Occupational therapists are strongly opposed to this view and are arguing to maintain their positions. A delay in the area of motor functioning was not considered to be a criterion to qualify for entrance into special education.

As a result of this state department influence, the role of the occupational therapist may become restricted. The staff members of both components of Program C supported the role of the occupational therapist. In Component C-1, some children who were not designated in their IEP objectives to receive occupational therapy received services in a group setting. Justification for this practice rested on the argument that correct modeling of motor activities facilitated development in children who had deficient motor skills. In addition, it was noted that any practice under the supervision of an occupational therapist benefited all students.

Another state department influence involved funding cuts for preschool screening programs. The allocation for the screening of each child was cut from $16 (1985) to $8 (1986). Screening staff believed that less money available for screening would reduce the accuracy of decision making which, in turn, might affect the in-depth diagnostic assessment process (e.g., in turns of the numbers referred for diagnostic assessment).

Issues Within the Program

Issues within the program were concentrated in three areas: (a) size, (b) location, and (c) staff. First, the number of children served in the early childhood program increased significantly within the past few years. This resulted in the split of the program into two distinct classrooms with distinct focuses. Growth in numbers of children being served appears to be a constant factor in programming.

Another issue within the district's early childhood programming was the location of the program. The program has moved each year for the past four years due to changes in the number of children served and the availability of facilities. Although Component C-1 will stay at its present site, Component C-2 will again be moving. This move is due to increased school enrollment within the district. As a result of boundary changes, the elementary school will require the use of several additional rooms for older elementary children. In order to accommodate these children, Component C-2 will be moving to another elementary school. The school board made this decision in March.

Another issue within the program was staff turnover. Reasons for turnover have included retirement, and relocations in other districts or states. This was only the second year that Component C-1 had the same teaching staff. In general, consistency in location and staff has been difficult to establish and maintain.

Preschool Screening

Definitions

Preschool screening (PSS) is conducted in District C to identify children with existing problems or children who are at risk for developing problems. As defined by the screening coordinator, the preschool screening process is used to look for possible problems that may exist. It is the purpose of the diagnostic assessment, which occurs after PSS, to further define that problem and determine whether the problem is a handicap. Figure C-2 is a representation of the flow of activities in Program C, from screening to placement.

Personnel

PSS in District C is under the direction of a screening coordinator. This person is assisted by several school nurses, a health aide, and numerous volunteers.

The health aide was responsible for scheduling screening appointments, sending letters with scheduled dates and times, and calling to confirm appointments. Several school nurses were employed to interpret test results, conduct exit interviews, and supervise volunteers who actually conducted the screening tests. Most of the volunteers had worked with the screening program before.

The screening coordinator (who also is a school nurse) was in charge of training volunteers. The volunteers were trained to assess development in one or two areas using the DIAL-R. Volunteers usually were trained in groups of two, but occasionally were trained individually or in groups of four (at most). Retraining does not occur each year for every volunteer, especially when a volunteer has worked with the screening program before. After training, the volunteer observes a trained person conducting the assessment in a particular area. Volunteers are supervised when testing their first two children.

In general, the personnel involved in preschool screening were satisfied with the tools and procedures they use. No formal evaluations of satisfaction have been conducted, however, because parents also seem to be satisfied with the screening procedure and tools used.

Content

The DIAL-R (Developmental Indicators for the Assessment of Learning-Revised) was the main tool used for preschool screening. Areas screened include motor skills, concepts, and language. When the DIAL-R was adopted, all volunteers were trained in its use, even if they were familiar with

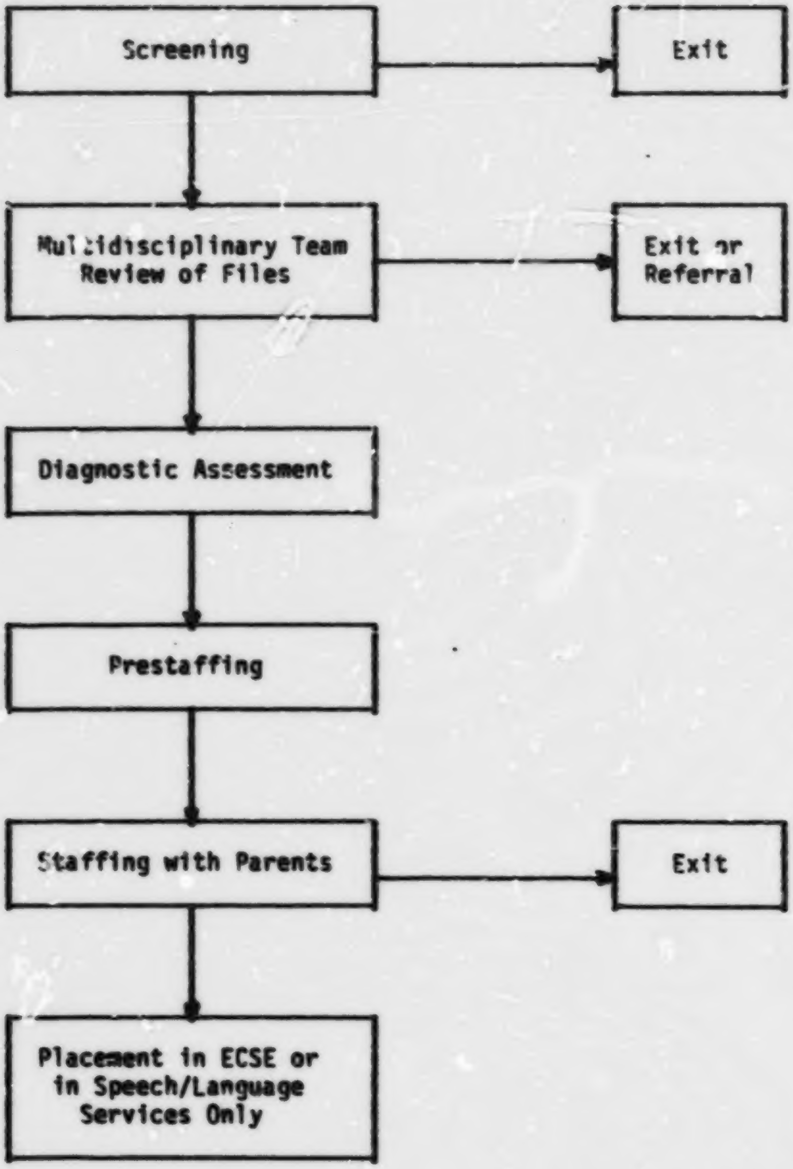
Screening
Exit
Multidisciplinary Team Review of Files
Exit or Referral
Diagnostic Assessment
Prestaffing
Staffing with Parents
Exit
Placement in ECSE or in Speech/Language Services Only

Figure C-2. Flowchart of activities in Program C from screening to placement.

the previous version, the DIAL. Administration of the DIAL-R takes approximately 25 minutes per child. A score is computed for each area, and then summed to get a total score. Tables are provided in the DIAL-R manual to determine cut-off points for successful performance based on age. Cut-off points are charted at 3-month intervals. The authors of the DIAL-R indicate that trained volunteers may administer the test sections. Standardization was stratified according to age, sex, geographic region and size of community for 2,447 children aged 2-0 to 6-0. Test-retest reliability for the sub areas ranges from .758 to .868, and the overall reliability coefficient is reported to be as high as .96 (Minnesota Department of Education, 1985). Evidence of content and some criterion-related validity is provided in the manual.

For hearing, the VASC (Verbal Auditory Screening for Children) was used. Criterion for referral is designated as a greater than 15 db loss in either ear. For vision testing, the HOVT (Matching Symbol Test) was used with criteria for referral designated as 20/50 or greater in one or both eyes. The illiterate E had been used for vision the year before, but was dropped.

In addition, the child's parent completed a health history questionnaire and a Communication Abilities Questionnaire (see example in Appendix C-1). A form also is completed by volunteers who assess hearing and vision.

The areas included in preschool screening in District C were determined by state mandates. Nutrition is not mandated by the state. Nevertheless, it was assessed when parents completed the health history questionnaire. The school district has responsibility for selecting the instruments to be used during screening; the instruments used currently are the same as have been used in the past (except for DIAL-R replacing DIAL).

All children are screened in all areas. Few children with significant handicaps participate in the screening. According to the health nurse, children with more severe handicaps are identified earlier by physicians or parents, and are already receiving services.

Time and Setting

Preschool screening sessions were scheduled on Mondays and Thursdays during February and March, for a total of 11 days. Screening sessions were from 8:45-11:30 am and 12:30-2:10 pm. The screening was conducted in several rooms at the district's administrative building (which also houses the Early Childhood Family Education program, and Component 1 of the Early Childhood Special Education program). Sections of the gym were designated for testing in particular developmental areas, with three different sections separated by moveable partitions. Additional stations in two band practice rooms were designated for vision and hearing screening. The main hallway was used for registration. The average amount of screening time per child was approximately two hours, with very little time between tests.

Participants

Census information was used to determine who was to be notified about preschool screening. The screening coordinator had a computer printout with the names and addresses of all families with children age 3½ to 5. After an initial letter is sent home, a health aide schedules every appointment by telephone. A follow-up letter confirming the date and time of the screening appointment also is sent.

During the Spring of 1986, children were screened in District C. That number was approximately half of the total number of children eligible for screening, as determined by census information. The characteristics of children who were not screened are unknown.

Participation in the District's screening program is a completely voluntary process. According to the screening coordinator, some parents do not take advantage of the preschool screening program because: (a) they do not feel that it is valuable, (b) both parents work and they can not bring their child to the screening, (c) their child may have been previously screened, and (d) they are just not interested. It was possible to reschedule appointments that were cancelled. If the parent and child failed to show up for the appointment, there was no follow-up. Children who are age 3½ will get another letter for preschool screening next year. Thus they do not necessarily miss preschool screening, but it is delayed until the following year. Other than an additional opportunity for screening next year for young children, no follow-up is provided for children who are not screened.

In addition to the census information, a notice about preschool screening in the district was placed in the local newspaper. Some calls from parents were received after this information was posted. Despite these two search methods, some parents of eligible children are not contacted about preschool screening. These generally are families that have recently moved into the district and were not included in the census data.

A small percentage of the children who were screened were referred from other community agencies. District C's early childhood education program works closely with a developmental achievement center (DAC). This DAC encourages parents to bring their children to the screening, especially for the vision and hearing testing. In addition, some referrals were received from nursery schools and private day cares. Formal notices of screening dates and times were not sent to community agencies or local physicians, etc.

Parents were responsible for getting their children to the screening appointment. The parents accompanied the children to the screening area, but they were encouraged to stay behind, and the children were assessed alone. Parents were asked to complete a health history questionnaire, which asks about the child's family health history, physicians, behavior, nutrition, immunization history, etc. Parents also were asked to complete the communication abilities questionnaire, which consists of 50 statements that are rated on a six-point continuum.

Feedback was given to the parents at an exit interview by one of the district's school nurses. During the exit interview the parent(s) and nurse discussed the child's scores on the DIAL-R. If the child failed the DIAL-R or if the child was within five points of the cut-off score, several alternatives are proposed. No rescreening was conducted with the DIAL-R; however, rescreening was conducted in the areas of vision and hearing. Occasionally during the exit interview, another vision or hearing screening test was scheduled, or a referral was suggested (e.g., family physician for immunization).

If a child was young (e.g., he/she would not be considered for kindergarten in the upcoming fall), failed test scores were generally handled in one of three ways. Occasionally children at this age may be considered "untestable." They may be shy, resistant, or may not understand what is required in terms of a response to structured demands. In these cases, the nurse may discuss or suggest the possibility of the child attending a regular preschool, or may refer the child to a Developmental Achievement Center (DAC). Second, the screening may be rescheduled for the next year. Third, the results may be discussed by a multidisciplinary team, which may recommend further evaluation. Apparently, many parents choose to wait until the next year, after another screening, before considering further intervention for their young children.

The performance of children who are four years or older tends to be examined with more stringent considerations. The behavior of children at this age who are uncooperative or resistant is noted and the child is more likely to be discussed by the multidisciplinary team than is a younger child for a decision about whether further diagnostic assessment is necessary. In all cases, the parent has the prerogative to conclude the screening process and discontinue further discussion or investigation of service or assessment.

Budget

The budget for PSS in District C in 1986-87 is based on a child count of individual screenings from 1985-86, which was 500. A breakdown of the budget is shown in Table C-6.

Referral Process

Within a month after PSS, children who failed the DIAL-R or were within a few points of the cut-off score were discussed by a multidisciplinary team of school staff who had training and experience with preschool children. Included on the team were two special education coordinators (one for early childhood special education and one for speech/language), the health nurse in charge of coordinating preschool screening, and the school psychologist for the early childhood special education program. The health nurse who was in charge of coordinating PSS selected the files to be discussed. Generally, children who were below the DIAL-R cut-off score for their age and children who were 1 to 5 points above the cut-off score were considered and discussed by the multidisciplinary team.

Decisions regarding referral for further diagnostic assessments are made at meetings of the multidisciplinary team. Three separate meetings were held in

Table C-6

Preschool Screening Budget, 1986-87

Nurse Coordinator (based on 9 hr/wk 1985 salary schedule)	$ 4,419.00
Clerical (1 hr/day for 180 days)	1,280.00
Fringes (dental insurance/sick leave, etc.)	291.00
Preschool Survey of Hearing and Vision ($2.00/child for 500 children [pre-set], original physicians wives/use some equipment)	1,000.00
Volunteer Coordinator (pre-set)	1,000.00
Postage (1000 letters sent at $.39/letter)	390.00
Supplies (DIAL supplies, envelopes, miscellaneous)	225.00
	$ 8,065.00
Proposed 1986-87 State Department Funding - $8.15/child (based on screening 500 children [child count from last year])	$ 4,075.00

March, each lasting approximately two hours. Decisions were made by considering performance in specific areas of the DIAL-R (e.g., motor, concepts, and language), number and quality of problem behaviors checked by the parent on the preschool health history form, parental concerns and input obtained in the exit interview, and other pertinent written comments by those conducting the assessment. Parent concerns also were noted during the team meeting (e.g., parent says child had a bad day, child is having difficulty with speech, child is difficult to control, etc.).

The length of time that a child was discussed varied as a function of the clarity of the case. If a unanimous decision was made for a referral, a preschool referral form (see Appendix C-2) was filled out by the special education coordinator. A complete screening file on a child would include a Preschool Referral Form, Communication Abilities Questionnaire, DIAL-R scoresheet, Preschool Health History Form, Physical Growth Percentiles, and a form with Participants Rights, Obligations and Assurances. After the file and forms were completed, the health nurse in charge of preschool screening contacted the parents about the referral for further diagnostic assessment across all areas or for a speech/language assessment only. The special education coordinator then telephoned those parents of children who had been referred to participate in the in-depth diagnostic assessment week. Specific concerns and further plans for evaluation were discussed. In addition to the telephone call, a form letter was sent to parents explaining reasons for further evaluation. If a child attended a nursery school or was in a day care setting, parents were asked for permission to call these providers in order to gather more information. If the parents comments and nursery school comments were much more favorable than the DIAL-R results, the team might decide not to conduct additional assessment. Parents are given the right to refuse diagnostic assessment, but all sources of contact encourage allowing participation in the evaluation.

Children generally were referred to one of three places for further evaluation. Most referrals went to a multidisciplinary child study team within the district that assesses children for a one-week period. Children exhibiting health problems were referred for further medical assessment by a family doctor or other health agency. If a child specifically exhibited difficulty in the area of speech, referrals were made to the district's speech clinician. Appointments were handled by a special education coordinator with background in speech and language.

The number of children screened in 1985-86 was 597. The number of files pulled for review by the multidisciplinary team was 47 (7.9%). The number pulled for diagnostic assessment by the child study team was 27 (4.5%). One parent refused the diagnostic assessment. Two other children were referred for diagnostic assessment from outside agencies.

Referrals were based on information that was both qualitative and quantitative. Some children who failed preschool screening, as indicated by results from the DIAL-R, were not referred for further diagnostic assessment. These children generally were young enough to qualify for screening again during the next year, or had parents who wanted to allow time for maturation. On the other hand, some children who passed preschool screening (based on DIAL-R scores) were referred for diagnostic assessment.

Of the children who eventually qualified for programming in the early childhood special education program (several others qualified for speech only services) and who went through screening (N = 9), five had failed preschool screening; the remaining four had passed preschool screening, but were within 2 to 4 points of DIAL-R cut-off scores. In the case of borderline scores, the decision to refer for diagnostic assessment generally was made if other information (e.g., parent concerns) supported a referral decision.

Diagnostic Assessment

Definition

The district's objective for diagnostic assessment was to identify children who were handicapped in one or more of the following areas: speech/language, cognitive/readiness, motor development, social-emotional or behavioral development, and who met the criteria for placement. In some cases, the diagnostic assessment of a child was limited to a specific area in accordance with referral concerns in a specific area. For example, a child may have passed preschool screening, but had scores on the language portion that were noticeably lower than scores obtained in the concept or motor areas. In addition, the parent may have expressed concern about the child's speech and language. In this case, only speech/language diagnostic testing would be scheduled. However, if the speech clinician who was conducting the diagnostic testing thought that there may be other areas of concern, a recommendation could be made that other areas be assessed as well.

The diagnostic assessment also might be limited if a recent comprehensive assessment had been conducted by an external agency. For example, one child received an extensive evaluation through a hospital. Results from the assessment were released to the district. Contact with the mother and personnel from the agency suggested that problems were primarily related to behavior. Thus, the district's diagnostic assessment focused on behavioral assessment using observation in the classroom and parent interview.

Time and Setting: Assessment Week

Diagnostic assessment occurred during a seven-day period in the spring, at the school where Component C-1 was located. Each child was scheduled to attend either morning classes or afternoon classes, which ran for 2½ hours each (9:00 to 11:30, 12:30 to 3:00). Children were pulled from the classroom for short periods of time (generally 20-30 minutes) by professionals conducting the assessments; an effort was made not to pull a child out for two consecutive testing sessions. Four different rooms were used, in addition to the gym, and each professional used one room for assessment. Assessment schedules were posted by the occupational therapists, and speech/language and readiness evaluations were conducted on a flexible basis whenever a child was available. A master list of children who had completed the entire assessment process was kept so that some children could be dismissed before the assessment week was over.

Participants

All children referred for diagnostic assessment were scheduled for assessment during the seven-day period. Parents were contacted by telephone by the special education coordinator and then they received a letter explaining the assessment week, along with a permission-to-test form. It was ultimately the parents' decision to allow their child to go through the assessment; if written permission was not obtained, assessment was not conducted. Bus transportation for children to and from the assessment site was available if needed. During 1985-86, 29 of the 30 children scheduled actually were assessed.

Parent Meeting

During the initial telephone contact, parents were invited to attend an evening meeting three weeks before the assessment week. The purpose of the meeting was to receive a more detailed overview of the assessment process and meet some members of the assessment team. This year's meeting was held at the district center 22 days before the assessment week. Assessment team members attending the meeting included the special education coordinator, speech/language clinician, occupational therapist, lead teacher of the C-1 Component, and two psychologists. Twelve parents (representing 9 of the 26 families) attended.

The meeting began with the special education coordinator making introductory remarks and outlining the assessment week. She gave examples of what typically happens on the first day of the assessment when children are asked to separate from their parents. She noted that three groups of children exist: (a) those that separate immediately and go to the toys, (b) those that take a while to separate and require reassurance, and (c) those that cry and will not separate. It was urged that the parents separate from their child and leave even if their child is crying; they were assured that the staff would be available to help the children become comfortable. In the past, if a child was extremely uncooperative, the parent might be called (after two to three days) to sit in on the assessments. In addition, the special education coordinator reminded parents to send or bring in permission slips.

After the introductory remarks, each professional representing a given area (e.g., motor, speech) gave an overview of their evaluation procedure. The speech clinician explained that she would see each child three times for 20 minutes each time, and assess receptive and expressive language and articulation. The occupational therapist explained that she would be assessing each child's senses and look at running, sitting, and fine motor skills. The occupational therapist also handed out an informational sheet entitled "Children Learn by Doing, and Occupational Therapy Helps Make Doing Possible." The lead teacher went on to explain that she would be looking at developmental readiness skills. She noted that the test materials mainly consisted of toys and the experience should be enjoyable for the child. She also handed out an informational sheet entitled "What to Tell Your Child," and stressed that parents prepare their child for the assessment week by emphasizing playing with toys rather than "testing." The psychologist explained that the role of the school psychologist had changed from previous years, and she noted that an IQ or intellectual assessment using a standardized test would not be used during the psychologist's diagnostic assessment. She provided two reasons for this: (a) many times results may be affected by the child's speech/language skills, which might yield invalid results, and (b) the scores tend to be somewhat meaningless because they often change dramatically during a short period of time. Thus, this year parents would be interviewed for 1 hour and 15 minutes because it was believed that their input was very valuable. In addition, each child would be observed in the classroom twice for approximately 30 minutes each time on different days. Children exhibiting behavioral problems would be observed more frequently and by more than one person.

After each professional had spoken, the special education coordinator asked for parents' questions. Sixteen questions were asked during this time. Several questions addressed placement issues, and the special education coordinator described the two Program components and kindergarten options. Other questions were asked about how the classes would be conducted, whether individual snacks could be brought with the child, what would happen if a child was extremely active rather than shy, and when results would be provided, etc. Most of the questions were answered by the special education coordinator, although the psychologist and lead teacher responded to a few or made comments to support the special education coordinator's remarks. Discussion and questions continued for 1½ hours. At that point the special education coordinator invited parents to look at the assessment classrooms. Before going to the classroom, each parent was asked to get the tentatively scheduled date and time for a parent interview from the psychologists. If parents were unable to attend at the scheduled times, the name and number of the psychologist was on the card and they were encouraged to call and reschedule.

Variance in the Diagnostic Process

The diagnostic assessment process typically is the same for all children involved in the assessment week. However, this year assessment did vary for four children. Assessments varied for two children because previous assessments had been conducted by outside agencies and because concerns were mainly in the area of speech. In another case, the child was assessed in the motor area only, because of spina bifida and because the parent did not feel testing in other areas was necessary. Another child whose assessment varied had exhibited behavior problems during preschool screening, but was believed to be very intelligent (possibly gifted). Testing occurred only in the intellectual area. Thus, this child was observed among peers in a classroom situation, the parent was interviewed, and a standardized intelligence test was administered.

Instruments and Other Methods Used for Diagnostic Assessment

Each professional in charge of a specific developmental area (e.g., speech/language) was responsible for determining what particular tool or procedure would be used. Prior to selection of a particular instrument for a given area, the instruments were pilot tested to determine whether the obtained information seemed accurate and useful. The instruments used during the 1985-86 assessment week are summarized in Table C-7, along with information on who

Table C-7

Diagnostic Assessment

				Time Spent (Minutes)	
Team Member	Number of Staff	Area to Assess	Assessment Instruments	Direct	Indirect
Special Education Coordinator	1	Cognitive Readiness	Battelle Developmental Inventory (cognitive section) Brigance (parts)	70	Miscellaneous Class Time
Special Education Teacher	1				
Speech Clinician	3	Speech/Language Development	Language Sample, Preschool Language Scale, TACL, Photo Articulation Test, PPVT-R, Structured Photographic Expressive Language Test	60	Miscellaneous Class Time
Occupational Therapist	2	Motor Development	Battelle or Miller Assessment Profile, VMI	75	Miscellaneous Class Time
Psychologist	3	Socio-Emotional Development Adaptive Functioning	Vineland Adaptive Behavior Scales (Socialization and Daily Living Skills Domain) Interview with Parents Observation	0	60 (Observation) 75 (Parent Interview)
Nurse	1	Vision/Hearing (if necessary)		20	Miscellaneous Class Time
				225	135
				Total = 360 = 6 hours	

administered tests and amount of time spent directly and indirectly for the assessment.

The instruments that were used for each of four areas in the year 1984-85 were the following:

Speech/Language Development: Language Sample, Word Test, Preschool Language Scale, TACL, Photo Articulation Test, PPVT, Structured Photographic Expressive Language Test.

Motor Development: Miller Assessment Profile, Gesell, Observation, Brigance, VMI.

Social-Emotional Development: Burks Rating Scale, Personality Inventory for Children, Observation, Parent Interview.

Cognitive Development: Kaufman, WPPSI, Stanford-Binet, Brigance, Gesell, Informal Testing.

The role of the psychologist changed substantially from last year's role. In the past, an intellectual assessment using the Kaufman Assessment Battery for Children, Wechsler Preschool and Primary Scale of Intelligence, or McCarthy Scales of Children's Abilities were used. This year IQ tests were replaced by extensive parent interviews and observation. This procedure was implemented for several reasons:

(1) Children's performance may not be an accurate reflection of ability because of behavioral difficulties, communication difficulties, shyness, etc. during testing.

(2) Scores generally are not stable over short periods of time for preschool children.

(3) Obtained information is not useful in planning an instructional program for the child and does not aid in the understanding of the child.

This year the psychologist's role consisted of interviewing parents using an informally developed format (see Appendix C-3), and also using the Vineland Adaptive Behavior Scales, Expanded Form, and Interview Edition in the areas of socialization and daily living skills. In addition, children were observed for 30 minutes on two different days (see observation checklist in Appendix C-4).

Assessment in the areas of cognition/readiness and speech/language remained similar to previous years, with minor modifications (see Table C-6). The instruments used by the occupational therapists did change. They chose to use the Battelle Developmental Inventory, Motor Development Section, for some children participating in the diagnostic assessment. Although the Battelle is a popular new instrument and appears to have good technical characteristics in terms of norms, validity and reliability, the occupational therapists had some concerns. A major concern involved the small number of items designated for wide age ranges, and normative information that was provided for one-year intervals. It was thought that this might result in the over-identification of children.

At a final assessment week planning meeting, it was suggested that a checklist containing some items that the Battelle did not include be used to gain qualitative information. In addition, those conducting the cognitive/readiness assessment with portions of the Brigance were going to incorporate some of the items on the fine motor scale to supplement findings with the Battelle. Return to instruments used in the past was considered, but the final decision was to try the Battelle. This was done systematically during assessment week by both using MAPS and administering the Battelle to several youngsters. MAPS and observation were used to qualify children; Battelle scores then were examined to determine whether they supported the decisions. Results suggested that they did.

Parent Reactions

Program C surveyed parents of children who participated in diagnostic assessment. The surveys were completed by 12 parents, including 9 whose children were determined to be eligible for the program, and 3 parents whose children did not enter any program as a result of the diagnostic assessment. All parent responses were very positive. They indicated that (a) test results had been presented in understandable language, (b) they had a chance to give information during the team meeting, (c) the assessment team made them feel they were part of the decision, and (d) the location and length of the meeting and the number of people attending were adequate.

Placement in Early Childhood Special Education

Definition

The district's definition of an early childhood special education program placement includes placement in either of two early childhood special education programs, which are considered Level IV placements (child is in a special education classroom for the majority of the time, with possible mainstreaming options available). Other possibilities that do not fit the definition of early childhood special education programming might include direct speech and language services only (Level III) once or twice a week for short periods of time (e.g., ½ hour). Another example might include placement in a regular kindergarten, with Level III services (provided less than half of the day). A concern expressed by Component C-1 staff members was that when a child is placed in a regular 2½ hour kindergarten class with Level III services, the child's day becomes somewhat disjointed and shortened. A child who needs the maximum kindergarten experience to enhance borderline skills (whether pre-academic, social, communication, interaction, etc.) may be pulled out of the class to receive special services, which cuts that time short and incorporates more transitions in and out of the classroom setting. For these reasons, staff prefer to recommend half day kindergarten and half day early childhood special education placement in Component C-2, which is located in a regular elementary school building with access to kindergarten programs.

Time and Setting

Tentative decisions about placement in the early childhood special education program were made at a team meeting that took place after the diagnostic assessment occurred. This team meeting was attended by the professionals who conducted the assessments in particular areas (e.g., occupational therapist, psychologist, etc.). After data were presented by these professionals, tentative recommendations regarding placement were developed. Approximately 10 to 15 minutes were spent discussing each child's case. Most cases were clear cut; however, some required more extensive discussion. In such cases, various alternatives were discussed, but the final recommendation regarding placement was made at a feedback conference that parents attended.

Feedback conferences were scheduled by the special education coordinator, with a maximum of 1 hour and 15 minutes scheduled for each (see notice form in Appendix C-5). In most cases, each professional who conducted the assessment was present at the meeting. The format of conferences generally consisted of introductions and introductory remarks followed by a summary of pertinent developmental family histories and various data from other assessment areas. Test data were explained using diagrams and examples of test items. An effort was made to discuss strengths as well as weaknesses in performance. Questions were encouraged and parents were asked to indicate whether they understood the information that was being presented. During the meeting an individualized educational plan (IEP) and individual program plan were written if placement was going to be recommended (see forms in Appendix C-6). After the IEP was completed, the lead teacher or special education coordinator reviewed it with the parent(s), summarized the placement recommendation, and asked for the parent signature. At this time, hand-outs regarding programming, transportation, and medical information were distributed to parents whose children would be in the program. In addition, a summary of assessment data is given to the parent (see Appendix C-7), along with a copy of the IEP. Labels for handicapping conditions were not used at these meetings, although specific services that a child would be receiving were discussed (e.g., speech and language).

When a child did not meet entrance criteria for special education programming, other recommendations were given. For example, in some cases, recommendations were made for behavior management or referrals to regular preschool programs or various support agencies were made.

Children may be placed without a complete diagnostic assessment on the basis of recommendations from other agencies that have evaluation information on the child. However, in most cases some form of diagnostic assessment (e.g., observation, parent interview, specific testing in one area, etc.) is conducted by the district to corroborate findings. In addition, further testing may be conducted when the child begins the program in the fall to update diagnostic information and review the placement decision. Duplication of current assessment data generally is avoided due to time constraints and the numbers of other children who are being assessed for the first time.

Criteria for Making Placement Decisions

Criteria used to make placement decisions were reviewed and revised at meetings in April and May. The early childhood special education coordinator led the review and revision process. Professionals representing the areas of speech/language, occupational therapy, cognitive/preacademics, intellectual, and social-emotional had been asked to review the Minnesota State Department criteria and make any necessary revisions or additions for discussion at a staff meeting. The following is a summary of a meeting at which entrance criteria were discussed.

Persons attending the meeting were the occupational therapist from Component C-1, two lead teachers from Component C-1 and C-2, the speech clinician (from Component C-1), the school psychologist (for both Components), and two special education coordinators. The special education coordinator in charge of the early childhood program opened the meeting and reviewed the state's criteria for entrance.

The first issue arose in response to whether a child could qualify for early childhood special education programming with a language handicap only. Currently, a child with a speech handicap only is served by a speech clincian. "If a child has a language handicap only, placement shall be based on a team decision whether s/he will be served by a language clinician or in a EC:SE program alternative" (Minnesota Department of Education, 1986). A question was raised about the severity of the language handicap. For example, if the child was greater than two standard deviations delayed as determined by various language tests, could the child qualify for Level IV placement based on this finding alone? In response, it was noted that in such a case, cognitive functioning would be delayed as well. Thus, the child would receive programming because s/he qualified in two areas.

The special education coordinator noted that she dropped the sentence regarding an identifiable syndrome since those children with such syndromes would probably qualify for Level IV service because of delays in two or more areas anyway. Although input was solicited regarding the decision, no substantial discussion followed except for responses indicating the decision was agreeable.

Another question, raised by a lead teacher, was about what to do in the case of children who are referred for service by an agency, but who do not meet the entrance criteria as outlined. The special education coordinator suggested that diagnostic placement be provided for a limited time. At this point, the issue of program exit was discussed. It was noted that exit from Components C-1 and C-2 was not to be a hasty decision, because the benefits of past programming and the benefits of further programming might be affected in a negative way. The need for professional judgment in such cases was emphasized. It was noted that it is necessary for new referrals to meet the designated entrance criteria.

This raised another question regarding the placement of children into the Component C-2 program if they did not meet criteria. It was asked whether the team should write separate criteria for placement in the Component C-2 classroom. This issue was tabled and it was decided that the special education coordinator would ask for input from the special education director. Currently, children who go from Component C-1 to Component C-2 are placed on the basis of team decisions that take the child's progress into account and give general consideration to the areas of speech/language, motor development, behavior, cognition, and preacademics. Specific scores that indicate whether a child is 1½ SD below in a given area are not typically presented in a specific manner. (After the question had been brought to the attention of the special education director, it was decided that separate criteria would not be written for Component C-2, and each case would be considered individually in order to determine the best placement.)

Another question was raised regarding whether separate criteria for referrals from kindergarten to Component C-2 should be written. One viewpoint, expressed by the special education coordinator, advocated trying Level III services in the kindergartner's home school before going immediately to a Level IV placement. This met with some dissention from staff members who noted that pulling a child from a half-day kindergarten to receive Level III service disrupts the child's day and further minimizes the experience in kindergarten that the child needs. In addition, it was noted that Level III services are usually not enough to remediate the child's difficulties.

It was suggested that a full-day kindergarten for such children would help the situation. But this alternative was not ideal because there was no one to monitor kindergarten children over the lunch hour. However, some children are in full-day kindergartens (half-day in regular kindergarten and half-day in Component 2), and monitoring over the lunch hour is voluntarily assumed by some staff. The psychologist suggested that a traveling management aide might be used for the purpose of monitoring over the lunch hour. It was noted that the special education director would probably not sanction this and the problem would not be solved because each school would require an aide. This issue was tabled; it would be raised at a meeting with the special education director. (After that meeting a memo was sent out from the special education coordinator summarizing responses to questions that were raised. It was decided that separate criteria for children referred from kindergartens would not be written. Each case would be examined individually by a multidisciplinary team to determine best placement. Class size of Component C-2 will be a primary factor in making decisions about placement and Level III options in the child's home or local school will continue to be an alternative for receiving special education services.)

It was also noted at the original staff meeting that the majority of children referred from kindergartens had not participated in preschool screening. It was suggested that it might be beneficial to screen children in August before they enter kindergarten. Apparently, each elementary school building independently determines what its policies are, although guidelines could be provided that would recommend kindergarten screening. Questions were raised about who would be responsible for the screening -- nurse? teachers? Discussion on this topic was deferred so it could be raised with the special education director. (Initially, it was suggested that a screening program could be piloted in two schools to weigh the benefits. The number of kindergarten students participating would be a factor in determining the program's worthiness.)

Another topic discussed at the meeting was whether Component C-1 would be divided into two classes. At this point it seemed that the numbers of children qualifying for service in Component C-1 would exceed state caseload requirements. It was decided that if this component split into two separate classrooms, the make-up of the classes would have to be determined by numbers as well as student needs.

Discussion returned to the topic of specific criteria in the area of speech and language. In general, Program C's criteria were in accordance with state criteria. A theoretical example of a child who was apraxic and had motor problems, though had higher functioning cognitive skills was discussed. The question was raised about whether this child would be served in a Level IV program, or whether such a child could be placed in the Early Childhood Family Education Program with Level III services. The recommended procedure again was to carefully consider such cases on an individual basis and make decisions based on team input.

The final Program C criteria for entrance are provided in Appendix C-8.

Programming in Component C-1

Goals and Objectives

Discussion with Component C-1 teachers and administrative personnel indicated that the primary goal of their intervention program was to prepare the children to be capable of functioning in a mainstream classroom. A copy of written objectives was not available.

The teacher's objectives fell into six categories. These areas were clearly delineated and overall objectives were posted in the classroom on large pieces of construction paper with large black lettering. The categories as posted are provided in Table C-8.

Instruction focused on the major components shown in Table C-8, but the program also included snack time, group social skills, group motor development, story time, field trips, and special days designated for celebrating (such as Valentine's Day).

Time and Setting

Programming for children attending Component C-1 occurred on half days, five days a week from 9:15 to 11:45 in the morning, and 12:45 to 3:00 in the afternoon. The program ran from after labor day in September to May 23 during the 1985-86 academic year. School in the district actually continued until June 5, but the duration of Component C-1 was shorter due to diagnostic assessments of children for next year's program. A letter was sent to all parents approximately three weeks before the end of school to inform them of the last day of school.

Instruction occurred in the main classroom. Children receiving special services in occupational therapy received these either in the gym or in the

Table C-8

Categories and Objectives Posted in Component C-1 Classroom

Area	Objectives
Self Help	To become independent lacing, buttoning, zipping, serving myself at the table -- pouring from a pitcher, spreading with a knife; cutting all with nice manners.
Cognitive Skills	Our ability to think and problem solve. Examples, puzzles, nesting toys, tinker toys, legos nuts and bolts, lacing boards or beads, sequencing activities, alphabet, numbers, pictures.
Speech and Language	To communicate with others. To increase vocabulary and concept development. To increase verbal expression -- describing, stating actions, sentence lenght. Pragmatics -- question comprehension increasing listening skills, improve articulation.
Fine Motor	Scissor cutting, pasting or glueing our crafts, pre-writing skills, coloring, tracing, and copying, play-doh.
Gross Motor	Using our large muscles to help improve balance and coordination, climbing structure, scooter boards, tramp, riding toys.
Social Development	Creative play in house keeping area, group play through board games -- following rules, special projects (e.g., carving a pumpkin).

occupational therapy room, which was equipped with large motor equipment. Children who received special speech services received therapy in another room (where C-1 teacher's desks and files were located) at a table adapted for the size of small children. The amount of time each child receives for individual therapy is determined primarily by the student's needs, based on test data, observation, and team input. The amount of occupational therapy a child receives generally ranges from indirect consultation services to three 20-minute sessions three times per week. Similarly, the amount of speech services generally ranges from indirect consultative services and monitoring to three 20-minute sessions each week. Examination of individualized educational plans indicated times that ranged from 10 minutes per month to 100 minutes per week for either speech/language or occupational therapy services.

In addition, each Component C-1 class was involved in a half-hour friendship/social skills group conducted by the psychologist once each week (see Appendix C-9). The group focused on talking about feelings and appropriate ways of interacting, and was structured using a book called Skill Streaming the Elementary School Child by McGinnis and Goldstein. The classroom teacher spoke highly of this intervention and gave anecdotal reports of significant progress made in the area of self-esteem and social skills; this progress was considered partially attributable to participation in the structured learning group.

The days on which children received special services were determined to a large extent by when the therapists/clinicians were scheduled to be in the building. In most cases, therapists worked part-time or were responsible for providing service at several schools. Of the 23 children in the Component C-1 classroom (two in process of assessment), 52% (n = 12) received speech/language services only, 4% (n = 1) received OT services only, and 44% received both (n = 10).

Participants

Component C-1 started with 21 children (January, 1986) and increased to 25 by the end of the academic year. The age of the children at entrance ranged from 4 (n = 18) to 5 (n = 7). Class make-up was not determined by age, disability, or severity of handicapping condition, although teachers noted that they would like to designate classes in a qualitative manner. Instead, assignment of children to the two Component C-1 classes (morning or afternoon) was determined mainly by children's addresses and busing considerations.

Parents were informed of the class content on a calendar that was sent home each month. The calendar includes descriptions of activities for each day. For example:

December 12, 1985
Fine Motor: Styrofoam balls
Cognitive/Fine Motor: Find three Christmas pictures and cut out
Language: Christmas vocabulary

Periodically, on the back of the calendar were lists of vocabulary words for the month, or concepts, along with the major motor development goal of the occupational therapy group.

In addition, a notebook with individual daily notes was sent home with each child every day, and returned by the child with comments from parents. These notebooks were used to facilitate communication between parents and the child's teacher.

Parents also were involved in developing their child's intervention program at meetings where IEPs (Individual Educational Plans) were written. Initial IEPs generally were written at parent feedback conferences after the diagnostic assessment week in June. These initial IEPs may be revised in the fall, soon after school begins. They are developed on the basis of diagnostic assessment data, work samples, and teacher judgment. For all IEP meetings, parents were sent notices in advance of conference dates and times.

IEP meetings generally ran smoothly, and the teachers were well prepared, receptive, and encouraging with the parents. Parents generally seemed comfortable, asked some questions and provided some qualitative information, although they ususally spoke considerably less than other team members. It appeared that recommendations about most decisions were prepared before the meeting, and that the parent's most important role was signing for permission to implement the intervention. However, some exchange was apparent and communication among all members was unrestrained.

Other communications between the parents and the program most often take the form of written flyers, due process forms, etc. Home visits generally are limited to interviews or brief assessments on children who are being considered for placement and in homes where transportation is difficult.

Very little formalized monitoring of progress is conducted in the classroom. However, the special education coordinator was actively seeking information about curriculum-based assessment methods that could be used on a daily or weekly basis. (The lead teacher in Component C-2 monitored progress using the Brigance administered twice per year and teacher-developed checklists and work samples.) It appeared that the specialists had better developed monitoring systems and could document progress from one therapy session to the next. For example, one occupational therapist used a form for each child that documented the date, activities worked on, and the child's strengths and weaknesses for each therapy session.

Personnel

Staff members in the classroom included the two co-teachers and a management aide. In addition, an intern student was placed in the program in the spring. She was to function in a role similar to that of an aide. The aide helped with such tasks as filing, making name tags, preparing snack, getting materials ready for projects, and supervising children. The aide was not involved in lesson planning or planning of activities. Sometimes, the aide read to the children at story time or interacted with them during activities.

Staff utilization generally was decided upon by staff members in a cooperative manner. A memo from the director of special education explaining staff responsibilities was distributed in September. It included the following for Component C-1: getting their own substitutes; informing the coordinator of schedules, meetings, and field trips; room scheduling; parent communications; and handling own child study tasks.

General classroom staff appeared to be satisfied with the quantity and quality of personnel serving the Component C-1 program. However, the occupational therapist and speech clinician indicated that they would like to spend more time with children, but were unable to do so because of the numbers of children that qualified for service and the limited amount of time allotted them at each school.

Content

The calendar of scheduled activities that is distributed to parents indicated that the majority of formal instructional time in Component C-1 is devoted to developing fine motor and cognitive skills. However, many of the areas overlap (e.g., social skills and cognitive skills, or fine motor and self-help skills). Thus, each area appeared to be addressed in equal manner throughout the year.

Most instruction occurred in a group situation or in a self-directed manner. Individual attention was given to each child periodically during group activities. In addition, teachers appeared to be aware of each child's weak areas and tended to provide more individual attention to those areas in an informal manner. For example, a child's sitting position was corrected duirng story time because motor development was of special concern. Children also received individual service and instruction if they were designated to receive speech/language therapy, or occupational therapy.

Mainstreaming

Because the Early Childhood Family Education Program had classrooms adjacent to those of Component C-1 this year, opportunities for mainstreaming were available. Mainstreaming into regular classrooms was not conducted the previous year when Component C-1 was in a different building. This year several children began to be mainstreamed into the preschool classes in November and later in February, coinciding with beginning quarters of the preschool program. Children were involved in a mainstream experience either once or twice each week. Five children were mainstreamed from the morning class for a period of 1 hour 10 minutes on Monday (n = 2) and for 40 minutes on Wednesday (n = 5). In the afternoon, seven children were mainstreamed on various days at various times.

Children who were mainstreamed were accompanied either by their parent or a teacher. Mainstreaming generally occurred during free time and unstructured play in the Early Childhood Family Education setting. Decisions to have children participate in mainstreaming were generally made at team staffings. Only those children with higher readiness skills and minimal behavior problems attended the regular preschool. An addendum was attached to each child's IEP once mainstreaming was decided upon (see Appendix C-10). Teachers who accompanied the children into the regular programs took notes (anecdotal observations) to help monitor the children's behavior.

Programming in Component C-2

Goals and Objectives

Similar to Component C-1, the primary goal of Component C-2 was to prepare children to be capable of functioning in a mainstream classroom. Most of the children were eligible to attend a kindergarten class because of their age, so the curriculum focused extensively on teaching pre-kindergarten/kindergarten skills. In fact, the lead teacher used kindergarten reading and arithmetic goals as guidelines for instruction. However, the lead teacher noted that individualized educational goals take precedence over the elementary school curriculum.

Time and Setting

The Component C-2 program ran from after labor day in September to June 3 during the 1985-86 school year. The academic program actually lasted two more days, but two school days were allocated to packing materials and furniture because the classroom was moving to another building for 1986-87.

Two class times were scheduled in Component C-2: 9:15 to 11:30 and 12:30 to 3:20. Programming varied extensively among children. Alternatives included: (a) attend C-2 half day (morning or afternoon); (b) attend C-2 half-day and mainstream into kindergarten half-day; (c) attend C-2 for all day; (d) attend C-2 as a homeroom, mainstream into first grade. In January, one child was being mainstreamed into first grade, and nine were being mainstreamed into kindergarten. Six children were receiving some type of full-day programming. To coordinate each child's schedule, the lead teacher worked closely with other staff members, including regular kindergarten teachers, special service providers (e.g., speech clinician, occupational therapist, etc.), the psychologist, the principal, and parents. Decisions were made formally at child study meetings when individualized educational programs were developed.

Participants

Component C-2 served 17 children. The ages of children served at the beginning of the year ranged from 5-0 to 7-11, with only two children who were 7 years and the others almost equally divided between 5 years and 6 years.

Both of the 7-year-old children attended school for a full day and were mainstreamed into first grade at certain times during each day. For example, one child was in a first grade classroom for homeroom, social studies, music, physical education, lunch, and health. Timing was arranged to minimize the number of transitions between the first grade classroom and the Component C-2 program. Although individualized programming was planned for each child, class make-up was not determined by the child's age or severity of disability.

Six families responded to a survey sent to Component C-2 parents as a part of this study. In answering a question on participation, two indicated that they had not visited their child's program during the year, one had visited one to two times, one had visted three to five times and another had visited six or more times. All of the responses indicated that they had talked with their child's teacher at least once, with most (n = 4) having communicated on three to six occasions. All six indicated that no one from the school program had visited their home.

School communication with parents generally occurred for three reasons: (a) conferences and educational planning meetings, (b) in-class participation, and (c) field trips. Written communication was generally in the form of personal notes, flyers, or the school newsletter. The lead teacher noted early in the year that one of her goals (revised every three years as prescribed by school building principal) was to increase parent contact. It seems that one of the means used to achieve this goal was to extend an informal invitation to parents to visit and participate in the classroom. Each child's IEP (Individual Educational Plan) was reviewed in November and May. These were discussed with parents at conferences. Notice of conferences were sent in advance and parents were encouraged to attend.

Initial IEP meetings with parents generally were run by the Component C-2 lead teacher. During the meeting, the lead teacher completed the IEP form. For this meeting, the teacher generally provided a summary sheet (typed) with the child's name, birthdate, psychological testing information, previous IEP objective date, and current grade placement. A space is provided for comments and recommendations at the end of the form.

Personnel

Intervention in the Component C-2 classroom was carried out mainly by the lead teacher. An aide was also in the room. Her responsibilities included supervising children in the lunchroom and on the playground, escorting children to and from the bus, documenting lunch count and attendance, reviewing flash cards with children, helping with clean-up, and preparing bulletin boards.

Other professionals involved in Component C-2 included an occupational therapist (part-time) and a speech clinician (full-time). A vision teacher also worked one on one (approximately 1½ hours daily) with a Component C-2 child who was blind. Speech clinicians and the occupational therapist worked with children individually for varying amounts of time, as determined at IEP conferences. Of the 17 children in Component C-2, approximately 53% (n = 9) received speech/language services only, and 47% (n = 8) received both speech/language and occupational therapy.

Content

The Component C-2 classroom schedule, developed by the lead teacher, was as follows:

9:15 - 9:30	open
9:30 - 10:30	reading and langauge activities
10:30 - 10:45	snacks and clean-up

10:45 - 11:15	arithmetic activities
11:15 - 11:30	motor activities
11:30 - 11:40	clean-up/ready for dismissal and lunch
11:40 - 12:30	lunch and recess
12:30 - 1:00	social awareness group
1:00 - 1:30	arithmetic and reading activities
1:30 - 2:00	art and music activities
2:00 - 2:30	social studies/science
2:30 - 3:00	music/storytime
3:00 - 3:10	dismissal
3:10 - 3:20	dismissal

In addition, 30 minutes were spent in the library on Wednesday mornings.

Because of the number of children involved, most of the intervention in the classroom was conducted by the lead teacher using a group format. However, individual attention was given to each child within a group. For example, in the morning while the group was discussing the calendar, each child got a chance to choose the number, date, change the weather sign, etc. Many of the children required some special individualized attention specific to their handicap, such as a phonetic hearing device. As the need arose, these special situations were discussed with the group.

Mainstreaming

One of the advantages of Component C-2's location was its proximity to regular kindergarten and first grade classrooms. During the previous year, mainstreaming opportunities had been limited to school assemblies, library visits, and occasionally for combining kindergarten classrooms for some smaller programs or recess. This year several children were mainstreamed into regular kindergarten settings on various days and for various periods of time. The decision to mainstream a child was made by team members at team meetings. Decisions were based on information provided by staff regarding the child's functioning in several areas (e.g. cognitive, readiness, behavioral, social-emotional). Information presented was generally qualitative in nature, although some quantitative data also were presented.

During the 1985-86 academic year, 9 of 17 children were mainstreamed into regular kindergarten settings. One child was mainstreamed into a first grade classroom for nonacademic subjects. Many of the children who were mainstreamed into kindergarten attended it for half day and attended the Early Childhood Special Education Program for the other half.

As difficulties presented themselves, the lead teacher and others involved with the child worked to find solutions. In one case, a child was acting out on the bus. This necessitated discussion with the bus driver and the parent to generate alternatives to build appropriate behavior. The seating program in the bus was modified and a reward system using M&M's was implemented. After a successful period of time when appropriate behavior was exhibited, the lead teacher went with the child to a restaurant for pizza as the ultimate reinforcement. This plan required extensive personalized attention and contact with those people involved with the child. Most children do not require such extensive plans.

When asked about the curricula used in the program, the lead teacher responded with frustration, noting the difficulty in finding curriculum specifically designed for an early childhood special education program. She indicated that goals for regular kindergarten classes generally were used and modified to meet the developmental needs of the children.

Exit and Follow-Up

Exit Criteria

Program C based its exit criteria on those developed by the Minnesota State Department of Education. The criteria were documented after discussion with the Early Childhood Special Education staff members in the early spring. Program C exit criteria are as follows:

1. When data documents that the child has: (a) achieved all IEP goals and objectives, and (b) demonstrated through systematic observation during a predetermined trial period, the ability to function in his/her non-special education environment without the provision of special education instructions and related services; or

2. When the child can more appropriately be served in another special education program or setting; or

3. When the child has reached age seven by September 1, unless a program variance has been obtained from the Special Education Section of the Minnesota Department of Education.

Children generally exit from both components in the spring, at which time placement is reviewed and the most appropriate placement is recommended. Decisions for exit at the end of the year are discussed at a team meeting. Members of the team generally include the special education lead teachers, special education coordinator, speech/language clinician, occupational therapist, psychologist, and any mainstream teachers who may have been involved with the child. Decisions were made on the basis of several pieces of information including recent diagnostic assessments, gains noted in areas of readiness as documented on the Brigance, informal observation, psychological evaluations and information regarding the family background or environment, and parent attitudes. IEP goals were not directly referred to in meetings that were observed.

As reported by the special education coordinator, several children graduated from Level IV special education services to regular placements. Specifically, 41% (n = 7) of the children in Component C-2 were placed in regular first grade classrooms, and 6% (n = 1) were placed in regular kindergarten settings.

Many children who exit from Component C-1 continue to receive special services in Component C-2 before going on into kindergarten. During 1985-86, the breakdown of placements for 25 children was as follows:

Placement	N
Remained in Component C-1	3
New modified C-1 program and kindergarten half day	8
Component C-2 and kindergarten half day	9
Kindergarten with speech service only	3
Regular kindergarten with no special services	1
Moved to another district's early childhood program	1

Exit During the Academic Year

Teachers from both components were asked about children who exited during the year. Three children exited Component C-1. Two (12%) exited because their families were moving to different districts. These children would continue to receive special services in the new districts, and their school records immediately were transferred. In one case, an exit conference was held with staff from the new program. The other transfer occurred suddenly, precluding a formal exit conference. However, staff from the new program called and spoke with the child's teacher to gather pertinent information.

One other child exited from Component C-1. He was originally referred by a hospital clinic, which had recommended placement because of social-emotional/behavioral difficulties. The child was placed in the program, but did not exhibit any significant behavior problems. Thus, a meeting with the referring clinic was held in addition to an exit conference, which recommended participation in the regular preschool (Early Childhood Family Education) program.

Of the children in Component C-2, one child exited because his family moved to another district. An exit conference was held and team members recommended that the best program for him in the new district would be a regular kindergarten. However, this decision was subject to subsequent evaluation and revision based on the child's progress in the class, and availability of other more appropriate programming.

Follow-Up

Follow-up in District C consists of a monitoring procedure used to check on how a child is progressing in new regular programming. Follow-up procedures are also used to determine whether further diagnostic assessment should be conducted and to determine further needs for special education services.

Follow-up of children who have exited from special services is a mandated district policy that is implemented by the special education coordinator and other staff. Follow-up for children who have exited from Component C-1 into regular preschool settings is conducted by the special education coordinator. Exit into kindergarten is generally followed by the building LD teacher. Other persons who might be involved with informal follow-up included the early childhood teachers and therapists who provided special services.

Each year the coordinator compiles a list of children who will be attending regular school settings and contacts parents and staff involved with the child to obtain indications of the child's progress. A follow-up report form is completed and filed for each child. The form documents information regarding the child's progress from a variety of sources, which may include: classroom teachers, parents, or special educators. If necessary (as determined by input received from parents and staff), a more in-depth meeting or an observation of the child may be scheduled. In some cases, names of children who are considered at risk for learning disabilities are submitted to special education teachers as a follow-up technique.

Follow-Up After Diagnostic Assessment

Informal follow-up is sometimes conducted after the diagnostic assessment is completed in the spring. Several cases will be described to give an indication of follow-up procedures after diagnostic assessment. (No formal procedure existed to determine when to follow-up a child.) The first case involved a child ("A") who passed the screening test, but was referred for diagnostic assessment due to speech and language concerns. Child A had been assessed in the area of speech and language the previous fall, and test scores indicated some delay. However, the child was not placed in the program because she was too young to qualify for service based on age criteria. In addition, her parents felt that special services were not necessary at the time. The diagnostic assessment that occurred this year was a means of following up on her progress. This year, child A qualified for speech services only. In addition, the psychologist noted concerns about social-emotional development and peer interaction. Because of these concerns, placement in a regular preschool setting was strongly recommended. A report was written that suggested ways to facilitate peer interaction in the regular preschool setting. Child A's mother was given the special education coordinator's name and number to contact in order to coordinate transportation and programming in the Early Childhood Family Education program. In addition, the speech clinician noted that she would be able to monitor progress in the classroom situation through informal discussion with A's mother and teachers.

In another case (child B), concerns focused on the area of social-emotional development. It was decided that the child might benefit by continuing to attend his present preschool. Program C's psychologist followed up on the case by visiting the child's preschool and providing some guidance in the areas where child B was having difficulty. Plans were made to re-establish contact in August to determine whether special services now were needed.

The last example illustrates the use of a diagnostic placement within the Early Childhood Special Education Program for a specified period of time to follow-up on concerns that were raised during the diagnostic assessment. This type of short-term placement occurs rarely. Such placements continue for about

6 to 8 weeks. These placements occur to examine more fully than possible during diagnostic testing the extent of processing difficulties, the child's learning rate, severity of difficulties across situations and time, response to environmental stimulation, etc.

Transfer of Information

Each program to which a child transfered received extensive information on the child. Information was not given to a new program if parents requested no transfer of information regarding previous educational services. This happened very infrequently. However, some parents have expressed concern about special education files following children into later grades and interfering or prejudicing teacher's opinions.

If information is requested about a new child, an extensive amount is available. Each child could have as many as six files. They included (a) cumulative file (containing basic information regarding enrollment, current grade level, etc.), (b) specialist file (containing notes and assessment information compiled by the child's teacher), and (c) child study file (containing due process forms, assessment summaries, individualized educational plans). Optional files depending on the service a child received might include (a) speech/language file, (b) occupational therapy file, and (c) psychology file.

Receiving programs were contacted ahead of time regarding the entrance of new students and staff were invited to a team conference. A goal is to have present all individuals who will be serving the child in the receiving school, in addition to the receiving school's principal. Program C staff members who were typically present at the meeting included the classroom teacher, speech clinician, occupational therapist, school psychologist, and special education coordinator. In most cases, the special education coordinator directed the meeting and participation generally was dominated by the staff of the early childhood special education program. This reflected the fact that most of the discussion time about each child focused on reviewing the child's case. Participation rates among Program C staff were fairly equal, and their specific roles were somewhat evident. The Program C staff basically served as data presenters. First, the teacher presented the information she had about a child, and then this was added to by the speech clinician, the school psychologist, and the occupational therapist. The staff of the receiving program generally took the role of questioners and clarifiers. The role played by the early childhood special education coordinator was basically that of moderator, pacer, and summerizer.

Summary

Program C reflected a sophisticated program, with a data-based approach to the decision-making process for preschool screening, referral, diagnostic assessment, intervention, and exit. Decisions were weighed carefully, with data moderated by the experience of personnel and their familiarity with the cases about which decisions had to be made. The program continued to function effectively despite repeated difficulties with locations (particularly isolation, separation, and moves), and despite schedules, transportation requirements, etc. that imposed numerous constraints on optimal service provision. Qualified personnel and dynamic leadership were key variables in maintaining the program.

Chapter 5: Program D

Paula A. Nania

Program D is an early childhood special education program in a small, rural community. It has one classroom in an elementary school and served 14 children during 1985-86. Youngsters in this program also receive services from an interdistrict special education cooperative, which provides several support service professionals, such as a school psychologist, a physical therapist, an EBD consultant, and others. A schematic presentation of the relationship among screening, assessment, intervention, and transition to the elementary school is provided in Figure D-1.

Program Description

Community Characteristics

Program D is located in a rural school district approximately 40 miles outside of a large metropolitan area. The district's total population is approximately 6000 (Bureau of the Census, 1982). In 1985-86 there were 765 children enrolled in grades K through 6.

Program D is located in a community of approximately 2,500. It falls at approximately the 60th percentile in the state for median family income, with 94% of families above the poverty level (Bureau of Census, 1982). In 1982-83, 1.6% of the student population was composed of minorities (Minnesota Department of Education, 1984a).

Physical Setting

Program D is located in a large three story building that also houses regular education kindergarten classrooms and grades 2 through 6. (First grade classrooms are located in another building approximately 10 miles away.) Program D uses the building's gym daily, but beyond that uses only its own self-contained classroom.

Program D's first floor classroom is large and well-decorated, with many contents: two teacher's desks, files, three large student work tables, a large open area half of which is carpeted, many storage cabinets, a sink and oven, an aquarium, a computer, book shelves, a time-out corner, a play kitchen, blanket storage, the speech/language clinician's work table, toy shelves, and many bulletin boards with teacher decorations and student work. Bathrooms and student lockers are located immediately outside of the room.

Program D's administrator likes the fact that "we're able to serve our own students at home, integrated with the rest of the student body." Parents were somewhat divided in their evaluation of the location of the school. Of those parents responding to a survey sent home with their child (43%, n = 6), one third were "somewhat dissatisfied" and two thirds were either "somewhat

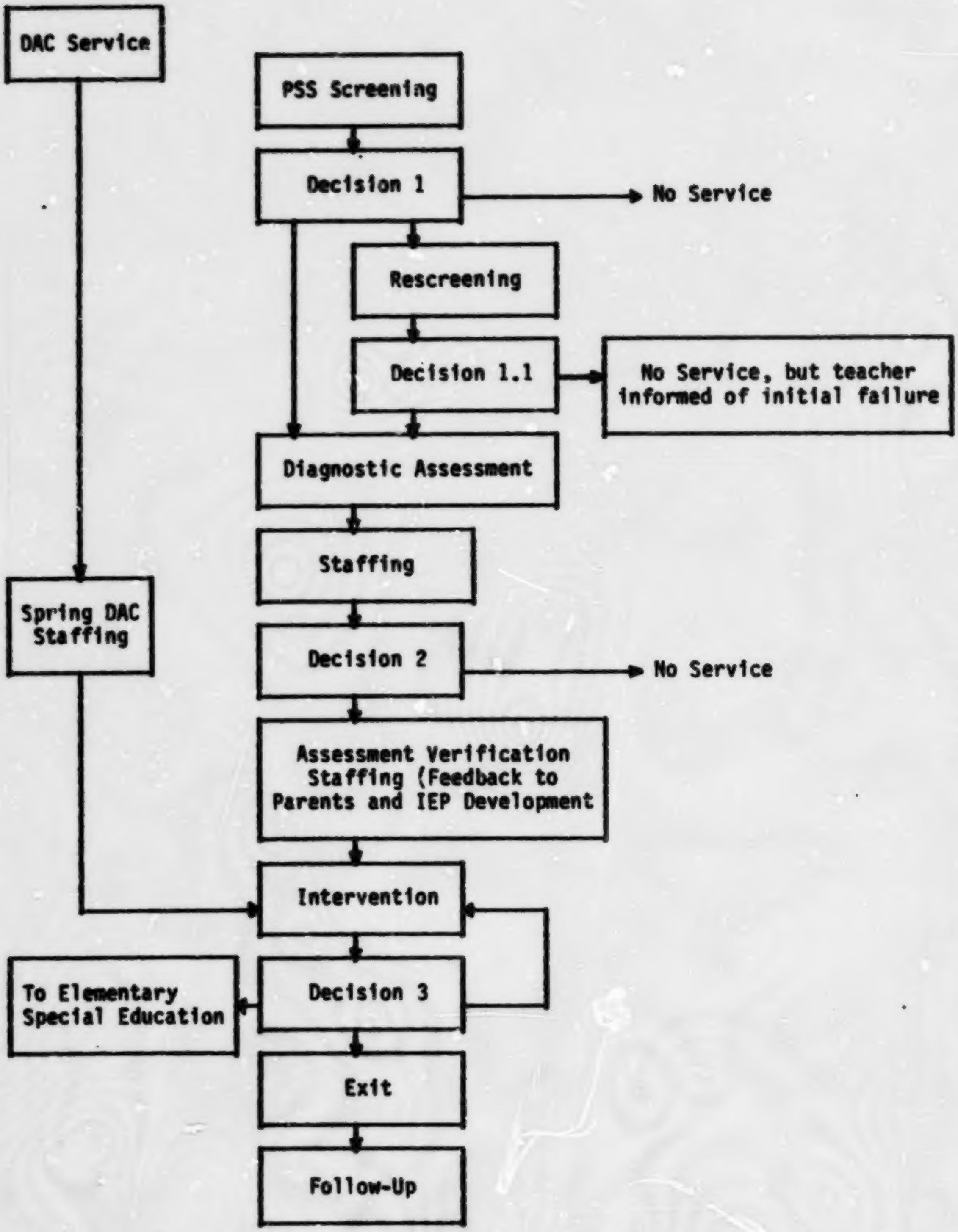
DAC Service
PSS Screening
Decision 1
No Service
Rescreening
Decision 1.1
No Service, but teacher informed of initial failure
Diagnostic Assessment
Staffing
Spring DAC Staffing
Decision 2
No Service
Assessment Verification Staffing (Feedback to Parents and IEP Development
Intervention
To Elementary Special Education
Decision 3
Exit
Follow-Up

Figure D-1. Major stages and decision points in Program D's early special education assessment and decision-making process.

satisfied" or "very satisfied". One parent commented that the program "is kind of out of the way." (Children from around the county are served in Program D.) However, all responding parents were "very satisfied" with the bus services provided for their children. One half of the responding parents were somewhat dissatisfied with the school building. Both teachers and administrator acknowledged that program enrollment has increased greatly in recent years and that space in the building is limited.

Organization and Staff

The elementary school principal also functions as the administrator of Program D. His responsibilities in this role include making placement decisions for graduates of the ECSE program, hiring and supervising the program's staff, and drawing up and submitting the budget to the district's superintendent. Under this administrator are five full-time staff members who work in Program D's classroom. There is one "early childhood special education teacher" who is certified to teach EMH and TMH, and is provisionally licensed to teach early childhood. She is actively working on an early childhood certification. This is her second year in the program. The two other members of the teaching team are speech and language clinicians who are present half of the day and who alternate the days they are present in the classroom. Two full-time aides also are in the classroom. Both have had previous classroom experience in varying capacities; they also receive inservice training through the special education cooperative.

Program D's school district is served by a special education Cooperative (Co-op) that serves 12 school districts, including three other ECSE programs. The Cooperative is housed approximately 20 miles away from Program D. Cooperative staff members are available to the entire elementary school, including Program D, on a regularly scheduled basis. Each Co-op staff member is available for different amounts of time. For example, one staff member spends one day per week at Program D, while another makes two half hour visits per month. Staff includes a corrective therapist, a hearing teacher/consultant, an occupational therapist, a physical therapist, an EBD consultant, a vision teacher/consultant, and a school psychologist. The classroom teacher remarked that she finds the Co-op staff personnel to be excellent resources, but wishes she had greater access to them. Co-op staff members often are not able to attend Program D's staff meetings, but instead send their reports.

Another Co-op staff member who serves Program D (and the three other-area ECSE programs) is the Early Childhood Coordinator. This Coordinator, currently in her sixth year in the position, is certified for TMH and EMH, has a master's degree in Learning Disabilities, and is finishing an early education degree. She is scheduled to visit Program D two times per month. She has no authority to make decisions for the program, but functions as a consultant, working primarily on program development and curriculum issues. She also works closely with the area DACs, and facilitates the transition process when children served at the DAC's are ready to enter the public ECSE programs. The Early Childhood Coordinator is supervised by the Co-op Director of Special Education, as are all other Co-op staff members. The Director of Special Education consults with Program D's administrator and gives him feedback from the Co-op's staff.

Another staff member who serves the students in Program D is the Special Education Lead Teacher. He is housed in the same elementary school building as Program D and works under the Program D administrator. His role is to guarantee due process procedures for the special education students in the elementary program and in Program D. He coordinates the preschool screening program and participates in IEP staffings and IEP reviews. When children exit Program D, it is the Special Education Lead Teacher who acts as the child's advocate and who has the responsibility to guarantee that placements are appropriate. He is also responsible for monitoring the students who leave Program D and remain in the district, in either special or regular education programs, for the period of time that the student requires identified special education services within the mainstream environment.

Overall, parents expressed satisfaction with the program and its staff. All responding parents were either somewhat or very satisfied with their child's teacher, the helpfulness of the staff, communication with the school, services provided for the parents, the education program, and the program in general. One parent made comments indicating concern about staff qualifications and the education program for Program D. Similar comments were made by individuals at various levels of the administration.

History

Program D has been in operation for three years. Prior to this program, level IV elementary students were served at the elementary school. They moved to the high school when Program D started. Program D was developed when the district recognized the existence of a population of children in the county's DACs who were soon to be four and no longer eligible for DAC services, and who would need services beyond those available in the level IV elementary program. Other sources also presented the district with referrals involving young children with more severe low incidence handicaps who also could not be served appropriately in the program that existed at that time. District personnel believed that it was desirable for the district to serve these children, and that it was most cost efficient to serve them in the district rather than sending them elsewhere. The program began with only four or five children and, as the Director of Special Education put it, was "struggling to stay open." Eight students were served during the second year, and in the third and most recent school year, 14 children were enrolled in Program D. The Director of Special Education felt that the increase could be attributed to greater sophistication in identifying children.

Rationale/Philosophy

According to the administrator, Program D aspires to serve all those children 4- to 7-years-old in their district who are in need of and eligible for the special services that they provide. Children with milder handicaps who do not meet eligibility requirements for Program D are served in other district and county programs such as the DACs, private nursery schools, and Headstart. Although the situation has not yet occurred, if a child's handicap would be too severe to be served adequately in the district, the child would be served out of district, usually in one of two nearby larger metropolitan areas. Other service alternatives include home-based care in which an itinerant teacher or Cooperative staff member provides service during home visits.

According to Program D's administrator, the philosophy of the program is to "provide as much service as the child needs, but no more." The desired outcomes and goal for each child is that s/he be able to function in the mainstream as much as he/she is able.

Other Influences/Anticipated Program Changes

In the Fall of 1985 a new system became operative in the area Cooperative that serves Program D. The system is thoroughly described in a manual put together by the Co-op. The manual includes thorough written descriptions of information pertinent to the operation of the special education services in the member districts such as monitoring rules, agreement/by laws, student eligibility requirements, staff job descriptions, budget information, etc. (see selected pages relating to Early Childhood: Special Education in Appendix D-1). For the 10 years previous to the formulation of the system, the district had been a "non-categorical" district (i.e., children were not given categorical labels when they received services). According to the Director of Special Education, "everyone enjoyed the flexibility, but in reality it did not meet the needs of the [level IV] kids." With the new system the district is now "categorical." The ECSE programs are non-categorical, but when the children leave these programs and enter other special education programs they are labeled. The Director of Special Education feels that "down the road we will be more categorical."

There has been much discussion surrounding possible program changes for the coming year. Currently, only children from 4 to 7 years of age are served in Program D (which is considered a level IV placement), and there are no other level IV elementary programs. When children are beyond the age of seven, they are terminated from Program D, and move into the elementary school and receive special education services in the area of their need. However, there are currently several 7-year-old children in the program who may need level IV services next year. Rather than changing Program D's criteria to include those children beyond 7 years of age, the creation of a new classroom was being considered. The proposed classroom, besides serving a cluster of TMH and EMH level IV elementary children, may also have served the younger ECSE children whose needs are more severe. This change would have been consistent with the trend to become more categorical and also, as the Early Childhood Coordinator said, to get the children into more specialized programs earlier if they need it. However, it was discovered after the end-of-the-year assessments that there were not sufficient numbers of children to merit establishing an in-house program of this type. After assessment it was determined that there was only one 7-year-old child with handicaps sufficiently severe so that it may be necessary to serve him out of the district. Other 7-year-old children previously served in Program D and recently terminated because of age restrictions will be receiving lower levels of service in the mainstream setting next year. One will return to his home district. Several 5-year-old children will be new to the program next year.

Program D's administrator also mentioned the possibility of a level IV EBD program being created. As a result, both elementary and preschool children eligible for the program (several have already been identified) would receive direct in-house service. Currently, if a level IV EBD placement is needed, the child is served outside of the district.

With the state mandate to serve 3-year-old children in the Fall of 1986, the district was recently deciding how to serve this population. It has been confirmed that the district will contract with their county's DACs to continue serving 3-year-old children for at least the coming year.

Beginning in the Fall of 1986 the area Cooperative will no longer employ social workers due to budget cuts, and so social workers will no longer be available to Program D. It is not likely that this change will have much effect since social workers had not been involved much in Program D in the past.

Program Budget

It was difficult to get a clear description of how and from what sources Program D receives funding. All federal monies for which Program D is eligible go directly to the Cooperative to fund their staff. The Director of Special Education does the state budget work for Program D, but all the state special education reimbursement goes directly to the district. Program D's administrator works out his building's budget and submits it to the district's superintendent. Program D's administrator discusses needs for staffing and materials with Program D's classroom staff before submitting his budget to the district.

Although there are limits on the funding available to Program D, which are tied to enrollment, the Director of Special Education believes that the district is "generous" and that "there are no problems with getting materials." The classroom teachers agree that materials are sufficient, but think that budgeting is inadequate in terms of providing enough staff members for the Program's growing enrollment.

Screening and Referral

Preschool screening in Program D's district is conducted for one week in April or May of each year in the school building in which Program D is located. This process is coordinated by the Special Education Lead Teacher. Parents of children eligible for screening are notified by the district in a letter detailing the process and the place and time. Children are considered eligible for screening if they will enter kindergarten the next fall and have not previously participated in screening or will be 5 years of age by September 1 of the following fall. In addition, children who are 3½- to 4-years-old may be screened if their parents have concerns. Announcements concerning the screening process are placed in the local newspaper and school newspaper, and information is sent to the local parochial school. Program D's Special Education Lead Teacher estimated that the notification process may miss one child per year, usually from a family who has just moved into the area. He also noted that approximately 12% of those targeted and informed of the screening procedure will choose not to participate. An estimated 100 to 125 children are screened each year.

Screening consists of the components required by the state (vision, hearing, height, weight, health history, and assessment of the child's speech and language, motor, social/emotional, and cognitive development), plus a dental hygiene exam. These services are provided at no cost to residents of the district. As also required by the state, Program D's screening process includes a summary/exit interview with each child's parents. According to the Special Education Lead Teacher, the entire process takes approximately 90 minutes.

Screening for dental hygiene, vision, and hearing is contracted to County personnel. The Special Education Lead Teacher noted that the dental screening performed by a dental hygenist is done at no cost, but that vision and hearing screenings are provided by trained vision and hearing technicians at a cost to the district of $3.00 per child. The entire Preschool Screening process is included under the district's community education budget. The state reimburses the district with up to a maximum of $16.15 for every child screened for 1986. This will decrease to $8.15 per child in 1987.

After height and weight measurements are taken, the child proceeds to a number of screening stations. Each station screens a different area of development using the Developmental Indicators for the Assessment of Learning (DIAL), and also makes observations relevant to social/emotional status. At each station, comments and the child's DIAL score are recorded on a card that goes with the child from station to station. Personnel performing the various aspects of developmental screening include a speech/language pathologist, Program D's classroom teacher, and a registered nurse (RN).

After all stations have been completed, the child and his or her parents have a short summary and feedback interview with the Early Childhood Coordinator from the Special Education Cooperative. At this point the Coordinator makes a decision as to whether the results indicate that the child has passed the screening, has failed screening and needs more in-depth diagnostic assessment, or requires a re-screening before a decision can be made. This decision is based on the DIAL norms, which are in the form of age cut-off scores, and the observation comments made by the screeners at each station. The Early Childhood Coordinator noted that the majority of children who fail screening have speech and language difficulties. The speech/language clincian who conducts the speech and language portion of screenings and assessments stated that if a child fails the screening in this area, rescreening does not occur; the child instead receives a thorough diagnostic assessment.

Rescreening is indicated when the child's score is low on two of the four areas assessed. Rescreening consists of a readministration of the DIAL. A decision to re-screen does not initiate due process procedures, whereas a decision for in-depth assessment does. In-depth, diagnostic assessment is indicated when three areas are low. At this point, the child is referred to the appropriate Co-op professionals. Children who fail rescreening are referred for diagnostic assessment. The screening results of children who fail the initial screening but pass re-screening are kept on file and the child's future teacher is made aware of the child's situation so that he/she may informally monitor the child's progress.

Diagnosis/Entry

Children who fail rescreening must go through a more in-depth diagnostic assessment before a decision can be made to place them in Program D. The primary goal of this diagnostic assessment stage is to determine the child's eligibility for special education services (Program D), as well as the extent of service that is required (e.g., direct service, indirect service, consultation). Diagnostic assessments generally are scheduled to be conducted in the spring so that placement decisions can be made for the following school year. These assessments take place at the school.

The Special Education Lead Teacher estimated that only about 3% of the children screened subsequently participate in a diagnostic assessment. Concurring with this estimation, records submitted to the state department indicated that Program D's district referred for diagnostic assessment 0% of those children screened in 1982-83. When asked about this low referral rate, the Early Childhood Coordinator explained by stating that most of the children eligible for Program D already have been served in DACs and therefore do not go through the screening process. She also stated that in the past, nurses and others with little background in education had conducted preschool screening; they would not often recommend educational interventions for children with problems, but instead gave parents the advice to "wait a year" before placing their child in kindergarten.

Several Co-op professionals were interviewed about their role in the diagnostic assessment stage. Some, such as the school psychologist, have had virtually no role. Spring is generally a busy time for the Co-op personnel and so their involvement is limited. A vision consultant for the Co-op similarly had very little to do with diagnostic assessment since children must be labeled as visually impaired by an opthalmologist and these children are usually identified long before preschool screening. The vision consultant serves as a liaison between the DACs and Program D for visually impaired children who will be entering Program D. The Co-op EBD consultant is not normally involved in diagnostic assessment except for the more extreme cases, which are relatively rare. In these instances, this professional uses teacher checklists, parent interviews, observations, and interviews with the student using a play therapy format to assess the child's emotional and behavioral functioning. An interview with the Co-op social worker revealed that she is not involved with the screening or diagnostic assessment process.

The corrective (physical) therapist (C.T.) receives referrals to assess children who have failed the gross motor component of preschool screening. She then uses her own checklist to further determine specific assessment needs. The instruments used by the C.T. at this stage include the Battelle Development Inventory, the Bruininks-Oseretsky Test of Motor Proficiency, and the Peabody Developmental Motor Scales and Activity Cards.

The occupational therapist also assesses children who have failed preschool screening. She noted that diagnostic assessment is done for each student on an individualized basis depending on his or her assessment needs. Children who are determined to have lesser needs from the assessment needs phase may receive only consultation.

The Early Childhood Coordinator stated that the team is beginning to use the Batelle Development Inventory for diagnostic assessment. In the past the Brigance Diagnostic Inventory of Early Development had been used, but was found inadequate because it lacks standard scores.

Assessment to Placement

The decision to place a child in Program D is made at a staffing following the period of diagnostic assessment, and is based on input from all team members who have had contact with the child. The staffing also includes Program D's coordinator and the Co-op's Early Childhood Coordinator. The Special Education Lead Teacher for Program D noted that these staffings usually do not involve people who are not part of the regular staff (i.e., outside consultants or medical professionals), but that written reports and other relevant information from professionals outside the system often are solicited and presented at staffings.

During the decision-making staffing, each team member who has assessed the child reports his or her results. This is primarily in the form of scores based on normative information for the individual assessment tool used and subjective input. The team then uses the assessment results to decide whether the child is eligible for services within Program D. (See Early Education: Special Education Eligibility Verification form in Appendix D-2.) Specific written criteria for entrance to special education programs do exist; these are separated by handicapping conditions. However, the program coordinator noted that there sometimes is a subjective component to the decision process in that judgment plays a role and that the team "can edit any written requirement (criterion)," although this rarely happens. (Due to time and scheduling constraints, no team decision-making staffings were observed.)

Following the team staffing is an assessment verification staffing, which serves as a feedback session to the child's parents. The IEP is written at this staffing if the child has been found to be eligible for services within Program D. Some of these initial IEPs are considered tentative (i.e., during the first 30 days of the school year additional formal and informal evaluation may be conducted and the IEP revised accordingly). An "inactive file" is kept on children for whom no action is decided or required. The coordinator noted that follow-up with these children is very informal.

Children served in the county's DACs do not go through the screening or diagnostic assessment process. They are automatically eligible to attend Program D if they meet Program D's eligibility criteria. Program D's staff, including the Early Childhood Coordinator, attend spring staffings at the DACs to facilitate the transition into Program D.

Intervention

Objectives

The district's objective for the children served in Program D is that they be able to function in mainstream settings as much as they possibly can. The classroom teacher's objective, similarly, is to prepare students for regular education kindergarten programs, if appropriate.

Time and Setting

Intervention takes place four days per week from 8:00 am until approximately 2:30 pm. The program is housed in the elementary school and is run on the same school calendar. No summer program is available in the district, but parents are encouraged to have their children attend the summer ECSE program in a nearby district that is served by the same special education Cooperative.

Personnel

Intervention is delivered through a "team teaching approach." The team is run by the full-time classroom teacher and the two half-time speech therapists. The team makes decisions concerning day-to-day programming and staff utilization. Although the functions of each staff member are defined, in reality there is flexibility in the roles assumed by the staff. The team has found that this approach works smoothly in the classroom. The two speech/language clinicians alternate days in the classroom. There are two full-time aides who work in the classroom and who also attend the weekly planning meetings. Their roles are generally ones of providing support to the teaching staff (e.g., taking data on child performance, working with small groups, checking independent work, helping non-ambulatory physically handicapped child get around the room).

Also serving the classroom are the Cooperative staff personnel. These staff members work as consultants to the teachers and provide assessment information. For example, the EBD consultant has devised behavior plans for one child in Program D this year. Since there is one visually impaired child in the program, the vision teacher/consultant from the Co-op provides all special materials and consults with the teacher concerning special considerations necessary in the classroom. Occupational and corrective therapists provide direct service to Program D two times each week, and write and monitor objectives for the children eligible for their services. All other Cooperative staff are available to Program D, and the classroom teacher can arrange consultation with those persons as needs arise.

One professional infrequently used by Program D is the social worker. The Co-op social worker reported that she is involved with students in the elementary school in which Program D is located, but has not received referrals concerning early education children. The social worker's only contact with Program D has been contacting the parents of one current student with behavioral problems. She hypothesized that her limited involvement with Program D is a result of a history of little involvement by social workers, and/or a higher need for her service with students of the elementary level.

An in-house adaptive physical education teacher also serves the children in Program D. She works with them as a small group two times each week and with eligible individuals one on one at other regularly scheduled times.

Program Participants

Program D serves children ages 4 to 7 years. In 1985-86, 14 children were served by five staff members who filled four staff positions (one teacher, one speech/language clinician, two aides) and provided direct service in the classroom. Since the classroom is the only ECSE program in the district, it is a multicategorical one. Although children are not labeled, most of the children served could be classified as mildly or moderately handicapped, and in the past year the majority of the students were served for speech and language concerns. In 1985-86, approximately one third of the 14 children attended Program D only in the mornings, and in the afternoons went to either the high school's regular preschool program, a regular kindergarten program, or home.

There is an "open classroom" policy wherein parents may visit the classroom at any time. According to the responses on parent surveys (n = 6), parents take advantage of this policy and visit their child's classroom "every few months." The teacher reports that parents do not visit often.

Parents also get involved through a notebook system. Approximately two thirds of the children have notebooks, provided by their parents, that travel back and forth between school and home. In this way, teachers communicate their concerns and the child's daily progress to the parents. The teacher believes that the parents appreciate this system, although the parents infrequently write any comments or questions in return. Of the parents responding to the survey, two said that they receive written notes from their child's teacher daily, three did so one or two times per week, and one did so one or two times per month.

Fridays, when children are not in the classroom, are used by the teacher to make home visits. She visits approximately two to three homes every week, and visits each home on the average of every six weeks. During these home conferences, the teacher receives parent feedback and offers suggestions for home interventions. According to the parents, in roughly the first six months school was in session the past year, someone from the school had visited them three to five times (n = 4), one or two times (n = 1), or never (n = 1). All responding parents indicated, however, that they had spoken with both the teacher and other school staff members on the average of every few months.

Programming

No one set curriculum is used by the teachers in Program D. They have described their intervention as "a language experience approach." They plan group activities to address the needs of the largest number of children. In the past year, since many of the children have had primarily speech and language concerns, most of the group activities have been focused on language. The team has also relied heavily on such group activities in the past year because of the large enrollment. Due to the number of students in Program D, the teacher said that she was not able to work one-on-one with each child on a daily basis as much as she would have preferred to do. It is during this one-on-one time that she generally works on more individualized needs and readiness skills, especially with the lower functioning students. During a daily 40-minute work period children are engaged in several of the following activities: one-on-one work with the teacher, individual speech sessions with the speech therapist, small group work with an aide, or, as the year progressed, independent table work (see daily schedule sample in Appendix D-3). The teacher and speech/language clincians have the most weight in making programming decisions for Program D's classroom. They are free to accept or reject the input of consultants. Changes in classroom interventions are made on a daily as-needed basis.

Progress is monitored formally twice each year, in the Fall and in the Spring, by the teacher and speech/language clincians. The Brigance Diagnostic Inventory of Early Development and the revised Peabody Picture Vocabulary Test (PPVT-R) are administered, as well as nonstandardized procedures such as charting, use of checklists, language samples, and videotaping. At any time of the year, the classroom team or Co-op personnel can request that a full reassessment be conducted. Otherwise, reassessment is conducted at least every three years. When reassessment takes place, a full team meeting occurs. Parents and all staff providing services to the child are invited.

IEPs

A team meeting takes place before all initial IEPs are written. Program D's classroom teacher is always involved in formulating the IEP when a child is to receive service in Program D (see Individualized Education Plan form in Appendix D-4). If the child has an IEP from a DAC or from another program, the teacher participates in revising it. Some initial IEPs are considered "30-day diagnostic IEPs," which means that there is a 30 school-day period in which additional testing can be conducted and the IEP revised. Once formulated, IEPs are updated mid-year and are changed if necessary in the Spring of every year that the child is in the program (see Periodic Review of Individual Education Plan form in Appendix D-5).

Exit

There are two ways in which a child can exit from Program D. The first is by becoming 7 years of age before September 1 of the following year and thus no longer being eligible to continue to participate in the ECSE program in the following year. According to the Special Education Lead Teacher, this is the case with approximately three-quarters of the children served by Program D (i.e., the children once placed in a level IV program continue to receive that level of service until they are no longer eligible because of age criteria set for the program; Program D's district has no elementary level IV placements).

The second, and less common way in which a child can exit from Program D is to meet all of his/her IEP goals and objectives or to make "suitable gains based on his/her age or grade." In this case the child exits from Program D gradually, receiving level III services, usually by attending a regular kindergarten program with support from resource teachers for half days with the remaining portion of the day being spent in Program D's classroom (see Instructional/Placement Levels of Service in Appendix D-6 for descriptions of the differing levels of service). The classroom teacher reported that when a child in her classroom reaches kindergarten age, if it is at all within the child's ability he or she will be placed in a regular kindergarten classroom for half days. This is estimated to occur in a little less than a quarter of the cases. An extremely small percentage of the students served in Program D, about 2% according to the Special Education Lead Teacher, will exit Program D and be phased out of all special education services within two years.

Placement decisions usually are made at the end of the academic year. It is rare that a child's level of service would change mid-year. Decisions are made at a full team meeting when parents are present. According to interviews with typical participants in such meetings, the classroom teacher, the Special Education Lead Teacher, and all other major service providers meet to discuss reassessment results. The outcomes of the team meeting are then relayed to Program D's administrator, who then approves the decision and, if there is to be a change in services provided, works on placing the child in the most appropriate setting.

Follow-Up

The district has a formal follow-up procedure outlined (see Termination/Follow-Up Report form in Appendix D-7) only for those children who are terminated from all special education services. In this very rare case "the district" is responsible for completing a follow-up report 12 months after services have been terminated.

In the more frequent case where children exit Program D at the age of 7 and continue to receive level III services, follow-up procedures consist of revising the child's IEP at least every 12 months. The classroom teacher stated that resource room teachers were responsible. The Early Childhood Coordinator acknowledged that there could be much better follow-up of children who exit Program D, regardless of what their subsequent placement is. One Co-op staff member, the EBD consultant, did state that for students with whom she has implemented a behavior plan, she informally follows them for approximately one year after she no longer provides service.

Summary

Program D reflected the adaptations involved in providing services in a rural area where the relatively low incidence of handicapping conditions makes services harder to obtain. The program has adapted well, although its relative newness is reflected in some disagreements among staff members.

The environmental constraints are recognized by those involved in Program D, but immediate solutions to those that create problems are not apparent. For example, the relationships with the Cooperative is restrictive because personnel from it must be on set schedules. Although Program D staff would like greater access to them, this possibility is effectively eliminated because of the structure of the Cooperative's services.

Transition issues also become more complicated because of the size of the district. Fewer programs are available, and children ready to leave the early childhood special education program were faced with no level IV services at the elementary level, until this next year when level IV EBD services will begin. Yet, such services would not likely be appropriate for the majority of children leaving the early childhood special education program.

Despite all difficulties imposed by its rural setting, Program D has a systematic approach to early childhood assessment and decision making. The unique characteristics of programs in rural settings and the nature of the problems encountered deserve further recognition and study.

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Footnotes

[1] School District Information sources included a special education preschool program handbook (1984), a school district annual report (1985) and student statistical report (1985), and a brochure (1985) about learning opportunities for preschoolers in the school district.

[2] In rare cases a child may attend Program A for more than one year. One child attended School 1 for the second consecutive year in 1985-86. Children in the School 1 Hearing-Impaired program may be served from birth until they reach kindergarten age.

Appendix A-1

Copy of Parent Survey Form

February 17, 1986

The Early Childhood Assessment Project at the University of Minnesota is studying different special education programs for preschoolers in Minnesota. We need to know how parents view the different programs we are studying. We hope that you will take the time to fill out this brief survey, and have your child return the completed survey to his/her teacher by February 21. The survey you complete will be kept confidential, and your name or your child's name will not be disclosed or appear in our results. If you have questions about this survey, please call Pat O'Sullivan at 376-2666.

CIRCLE ONE ITEM

What is your child's sex?		girl		boy	
How old is your child (in years)?	2	3	4	5	6
How many times have you visited Longfellow?	0	1-2	3-5	6 or more	
How many times has someone from school visited your home?	0	1-2	3-5	6 or more	
How many times have you talked to your child's teacher?	0	1-2	3-5	6 or more	
How many times have you talked to other school staff members?	0	1-3	4-7	8 or more	

In the areas below rate your level of satisfaction where:

1= Very Dissatisfied
2= Somewhat Dissatisfied
3= Somewhat Satisfied
4= Very Satisfied

CIRCLE ONE ITEM

Your child's education program	1	2	3	4
Your child's teacher	1	2	3	4
Services for parents	1	2	3	4
Bus services	1	2	3	4
Communication with school	1	2	3	4
The school building	1	2	3	4
Helpfulness of school staff	1	2	3	4
Location of the school	1	2	3	4
The Longfellow Program (Overall)	1	2	3	4

Please write any additional comments about the Longfellow Program, or this survey on the back of this survey.

Appendix A-2

Program A Team Meeting Summary

Purpose & Setting: The purpose of this Pre-SST meeting was to review and discuss results of the final four-day assessment session of the year, which was completed on the previous day. This Pre-SST meeting preceded SST meetings where assessment results and the team's recommendations regarding placement are discussed with parents. Assessment results for individual children were presented, and decisions about program eligibility were made (i.e., Was the child handicapped?). Assessment results for seven children (4 boys, 3 girls) were discussed. The meeting was conducted in the assessment classroom, and team members sat around a small rectangular table in child-sized chairs. The meeting was scheduled for 10 AM, but began at 10:05 and ended at 11:08. Discussion of cases actually stopped at 11:00 AM, and was followed by discussion about what to do with children who had not been assessed -- Should another assessment session be scheduled for the 8-9 referred children who had not undergone assessment? A median time of seven minutes (X= 7.9 minutes) was spent discussing each of the seven children, and the time for discussing each child ranged from four to seventeen minutes.

Roles & Participation: The Early Childhood Special Education (ECSE) Teacher, Teacher Aide, Psychologist, Social Worker, Speech Clinician, and School Nurse attended the meeting. Parents, professionals from other agencies, and administrators typically do not attend these Pre-SST meetings. At 9:55 The ECSE Teacher, Teacher Aide, Social Worker, Psychologist, and I sat around the table talking informally, and waiting for the Speech Clinician and School Nurse to arrive. The Social Worker left the room without explanation at 9:58 and returned at 10:05, when it was decided to begin discussing cases without the Speech Clinican and School Nurse. The Speech Clinician joined the team at 10:10, and the School Nurse arrived at 10:40. The Social Worker left the meeting at 10:55, and other team members stayed until the meeting's end at 11:08.

All team members participated in the meeting by speaking, although the School Nurse and Teacher Aide seemed to speak less than other team members. Discussion of cases typically began with the ECSE Teacher introducing the next case by saying, "Who's next?", or "Let's move to _____", for example. Then the Teacher or Psychologist presented test scores from the Brigance, and mentioned whether the child qualified in the Readiness area based on the Brigance age score. Other team members followed by presenting test results, and their decision or opinion about whether the child qualified for services at Program A. More informal discussion about the child's classroom behavior, parent reports, and sometimes evaluations completed by other agencies followed presentation of test data. If the child was identified as being eligible for services at Program A, the Teacher asked the team to provide or confirm a rating of the intervention level on a five-point scale. The intervention level rating scale is used by the Program Director to balance the severity of child behavior problems, when assigning children to intervention classrooms. Although most team members participated about equally, the ECSE Teacher appeared to assume a "task manager" role, leading the team from discussion of one child to the next, and guiding discussion at times. The ECSE Teacher often presented the most information about the child's behavior in the classroom, which seemed to carry considerable weight in decision making, aside from test results.

Data: Table 1 presents a summary of the sources of assessment information presented during the Team Meeting. Only information that was presented orally by team members was entered into Table 1, although other assessment data may have been collected, and/or summarized on paper. Printed materials were not handed out at the meeting. Brigance age scores and information gathered during parent interviews were the only sources of information presented for all children. Note that results of cognitive assessment, such as intelligence test scores, were not presented, since none of the assessed children were referred because of cognitive difficulties, or thought to be cognitively-impaired during assessment. The team seemed to rely primarily on test score cut-off points to determine program eligibility. In several instances however, the validity of test scores was questioned because test administration was incomplete.

Other Influences: Before the Team Meeting began, discussion focused on the difficulties associated with assessing many children in a relatively brief time span. Since this was the final regular assessment session, the team had assessed hundreds of children over the past six months, and the caseloads of team members was near its maximum, since the enrollment had been gradually increasing throughout the year. The Teacher Aide, who was involved in assessing children in both morning and afternoon sessions, mentioned that she had trouble remembering who all the children were. The rather hectic assessment pace also led to case managers not being assigned before assessment, according to the ECSE teacher. Despite the busy schedules and difficulties involved with assessing many children, the assessment team interacted in a relaxed, open, and friendly manner. The only apparent effect of the hectic schedule seemed to be more frequent interjection of humorous remarks, compared to a previous Pre-SST meeting I attended.

In one case, the Social Worker asked the team if a question of sexual abuse had been raised. The Social Worker commented that a report from the child's day care mentioned that he had french kissed a day care worker. After a brief silence, the Social Worker said the child could participate in a parent-child group at

Program A. The child had been identified as qualified for services in the Social-Emotional area.

For one case, the availability of openings at Program A may have influenced decision making. The child was in a "questionable" area as far as being eligible for Program A services, and ultimately was placed in an intervention classroom for six weeks of additional assessment. The Psychologist justified the temporary placement by saying, "We're not taking placements away from anyone at this time of year."

Decisions: At times it was difficult to determine whether a child had been admitted to the program or not. At the end of the meeting, the Speech Clinician summarized decisions about children by saying only two children had not been admitted to Program A. One of these two children was found eligible for "Speech Only" services, which involve brief speech therapy sessions at Program A or a neighborhood school. The other child was not programmed, but additional information from a private day care was to be gathered. So depending on how one considers children receiving only speech therapy, either 5/7 or 6/7 children were admitted to Program A. Also, in one case it was difficult to determine whether the eligibility decision had been postponed pending six weeks of further assessment, or if the child was considered eligible for services and supplemental assessment was recommended. A need for further assessment was mentioned for five children, and is typically conducted for children entering the intervention program, as well as those undergoing the additional six week assessment process. Four children were identified as handicapped in the Social-Emotional area, one child in the Readiness area, one child was eligible for speech-only services, and a decision was postponed for one child.

Sample Cases: The following examples describe discussion of an apparently "easy" decision case, and a "hard" decision case:

Easy Decision Case. The ECSE Teacher began discussion about this girl, after asking if there were any additional comments about the child discussed previously. The Psychologist said the girl had earned a 5-0 age score on the Brigance, and the ECSE Teacher commented that she was not going to qualify for the program. The teacher continued, saying she copied geometric shapes accurately, and earned her lowest Brigance score (4-0 years) in the speech area. The Speech Clinician said her speech was "Not too bad", that her mean length of utterance was 4.5, and the language complexity index was 3.04, although she had scored 3.6 standard deviations below the mean in speech articulation (Photo Articulation Test). The speech clinician concluded that she would be a "speech only" child, and not a "program child." Thus, she would be bused into Program A for speech therapy sessions, or attend sessions at a neighborhood school if they were available. Discussion of this case lasted four minutes.

Hard Decision Case. The ECSE Teacher introduced this boy as the next case, and the Speech Clinician commented that he was a "strange kid." The Speech Clinician added that he had a mean utterance length of 4.5, complexity index of 3.9, and was 85% intelligible. She spoke of his "bizarre answers" during assessment, and recounted a story that was read to him about three little kittens in a box. This child summarized the dictated story by saying, "He popped out his stomach." The Speech Clinician said other responses were irrelevant, and that he qualified for "Monitoring" in speech, but was not eligible for speech services. The Psychologist said this boy earned a 4-0 age score on the Brigance compared to his chronological age of 64 months (5-4 years). Then the Psychologist corrected the Brigance score to 4-6 years, after the ECSE Teacher pointed out an error. The Psychologist continued by saying he scored low in speech/language and self-help areas (4-0 years) of the Brigance, and earned a score of 5-0 years on other subtests. The Social Worker said he was rated 2.3 standard deviations below the mean on the parent-completed Personal-Social scale from the Batelle. Then, the Psychologist asked if he qualified in the Readiness area, and the Teacher said that he did not. The Teacher described the boy as shy, although he regularly responded to verbalizations directed toward him. He interacted infrequently with adults, and appeared to have self-concept difficulties, according to the Teacher. The Social Worker added that his mother had two heart attacks, and that the boy becomes concerned about his mother's trips to the hospital. The Psychologist said, "I'd keep him", meaning that he should be accepted in the program. The Psychologist described him as "very sad appearing" and quiet, jokingly introducing a novel diagnostic category -- "Weird Around the Edges." After the laughter subsided, the Teacher said he "did alright on tasks", although the quality of his responses was weird. The Teacher agreed with the Psychologist, saying "I'll go along with taking him." The Teacher then spoke for team explaining that the boy would be programmed for six more weeks of assessment. She continued, saying that he was not an acting-out type of child. The School Nurse interjected, saying that he did not talk until age four, according to the parent. The Psychologist gave a rationalization for accepting the child into the program despite not being sure of the decision, saying, "We're not taking placements away from anyone at this time of year." Discussion of this case lasted seven minutes.

Table 1. The number of occassions sources of assessment information were mentioned during the team meeting (Total Possible = 7).

Source of Information	Number of Times Mentioned
Brigance Age Score	7
City A Language Subsystem	5
Photo Articulation Test	2
Batelle Personal-Social Score	5
Parent Input From Interview	5
Classroom Observations	6
Evaluation From Other Agencies	2

Appendix A-3

Brigance Recording, Administration, and Eligibility Worksheet Used at Program A

TEMPORARY DRAFT OF BRIGANCE RECORDING 9/24/85

CODING:

Put in box at left:
F = formal (standardized means)
I = informal
O = observation
P = parent observation
R = records; info in file
U = unique

DNA = did not assess
0 = correct response
/ = incorrect response
(record what it was)
- = stopped testing here

Sections A & B combined and assessed by OT administration ofitems
Section C by teacher and aid administration of items
Section D by social worker and nurse using parent ~~observations~~ interviews
(P) of these items: D-1; # 26 - 29 D-3; #3 on thru
D-5; #3 on thru D-6; all items
D-7; all items D-8; #8 on thru
D-11; all items
Section E is omitted
Section F by speech clinician administration of items F-1 and F-2 and by teacher and aid administration of F-3, F-4, F-5, F-6B:2, and F-8
Section G by psychologist administration of G-1B:3 & 4, G-2, G-3, G-10 and G-11. Unique items are used for G-4, G-5, G-6 and G-7. Other G items are omitted.
Section H by teacher administration of H-1 only.
Section I, Section J and Section K are omitted.

Developmental Age Equivalents for 25% and 33% Delay:

Chronological age		25% delay	33% delay
4.0	48 months	36 months	32 months
4.1	49	37	32
4.2	50	38	33
4.3	51	38	33
4.4	52	39	34
4.5	53	39	34
4.6	54	40	35
4.7	55	40	36
4.8	56	41	36
4.9	57	42	37
4.10	58	43	38
4.11	59	44	38
5.0	60	45	39

30% delay is acceptable.

Appendix A-4

Copy of Behavior Checklists

Student's name:____________________ Dates:_______ Observer:_________

Classroom social-emotional skills; ages 4 to 5 years

Circle those demonstrated and mark highest level shown in each area.

1. Ability to follow verbal directions
   - a. attends to verbal messages from adults
   - b. demonstrates desire to comply
   - c. follows 1 step directions given by proximate adult to him/her as individual
   - d. follows 1 step directions given by adult to group
   - e. demonstrates understanding of 2 step directions given to group
2. Group skills
   - a. attends to teacher; focuses, looks, listens
   - b. demonstrates group membership thru choral responding
   - c. responds as an individual when directed/requested; able to wait and to take turns
   - d. joins group activities willingly
   - e. participates without disturbance or disruption to group
3. Communication skills
   - a. responds to greetings
   - b. answers others' questions
   - c. initiates verbal interactions
   - d. communicates needs and wants verbally
   - e. communicates knowledge verbally
4. Self-help skills
   - a. toiletting, dressing, eating
   - b. able to stay in designated safety boundaries, such as within the classroom, with the group in hallways etc.
   - c. able to use play materials and playground/gym equipment with appropriate level of help/instruction from adults
   - d. demonstrates understanding of classroom routines and schedule
   - e. cooperates in clean-up activities
5. Mutuality in adult and peer interaction
   - a. Able to participate in classroom without parent
   - b. Able to respond to adults' attention, praise and encouragement
   - c. Responds to peers' initiations and initiates interactions with peers
   - d. Engages in cooperative play
   - e. able to wait for adult attention when necessary; to share adults in classroom

Student____________________ Dates:__________ Observer___________

Specific problem behaviors observed in assessment period:
Give date and time for each.

1. Aggression: Verbal Physical
   Adult Child Self Materials/equipment
   Describe:

2. Dominating/controlling with peers
   Describe:

3. Resistant/oppositional:
   Actively Passively
   Interpersonal Activities
   Describe:

4. Withdrawn/isolating
   Adults Peers Activities
   Describe:

5. Overly-compliant
   Adults Peers
   Describe:

6. Fearful
   Adults Peers Activities Materials/equipment
   Describe:

7. Other problem behavior:
   Describe:

General description of child's classroom readiness behavior:

Appendix A-5

Standardized Peer-Referenced Observation Schedule Used by a Psychologist at Program A

School ______________________ Student ______________________________ Grade __________

Observer ____________________ Teacher ______________________________ Date __________

Time Interval Observed from ___ to ___ Setting ______________________________ Intervals are 30 sec.

TARGET

	1	3	5	7	9	11	13	15	17	19	21	23	25	27	29	31	33	35	37	39	RPM=rate per min RPH=rate per hr
off task																					___÷20x100=___%
physical																					___÷10 ___RPM x60___RPH
vocal/noise																					___÷10 ___x60___
place																					___÷10 ___x60___
compliance R 0																					___ R÷0=____%

PEERS

	2	4	6	8	10	12	14	16	18	20	22	24	26	28	30	32	34	36	38	40	
off task																					___÷20x100=___%
physical																					___÷10 ___RPM x60___RPH
vocal/noise																					___÷10 ___x60___
place																					___÷10 ___x60___
compliance R 0																					___ R÷0=____%

Off Task ____

Physical/Contact ____

Vocal/Noise ____

Place ____

Compliance ____

BEH-OF
#09230

DIRECTIONS

Off/on task measures are sampled at the onset of each 30 second interval. Every thirty seconds look up and record a mark if the student is not looking at or toward the directed educational stimulus.

Physical, vocal/noise and out of place are recorded as they occur across each 30 second interval. Record each discrete response occurring within each interval or mark a single response in each box when the response occurs continuously across two or more consecutive intervals.

KEY

Physical: Inappropriate contact or hurling of objects, damage to property or inappropriate motor behavior: Inappropriate is a function of context, duration of context, duration of intensity.

Vocal/Noise: Inappropriate accoustic responses not listed otherwise as physically inappropriate: Inappropriate is a function of context, duration or intensity.

Place: Out of explicitly or implicitly defined locations.

Compliance: Is a measure of student responses per opportunity to respond. Each time a group or individual directive is given, mark below the diagonal line of the box for the interval in which the directive is completed. Mark above the diagonal line of the box for the interval in which compliance with the directive occurs. The total number above the diagonal represents compliance responses and the total number below the diagonal represents opportunities.

SUMMARY

		OBS 1	OBS 2	OBS 3	Median	Greater median # ÷ smaller median #	Discrepancy
On Task	T	____	____	____	____	____ ÷ ____	= ____
	P	____	____	____	____		
Physical/ Contact	T	____	____	____	____	____ ÷ ____	= ____
	P	____	____	____	____		
Vocal/Noise	T	____	____	____	____	____ ÷ ____	= ____
	P	____	____	____	____		
Place	T	____	____	____	____	____ ÷ ____	= ____
	P	____	____	____	____		
Compliance	T	____	____	____	____	____ ÷ ____	= ____
	P	____	____	____	____		

Target = T; Peers = P

Appendix B-1

EARLY CHILDHOOD PROGRAM

INTAKE FORM

Date ____________
Intake by ____________
Referred by ____________

Child's Name ______________________________ Date of Birth ____________

Parent/Guardian ______________________________ Home Phone ________ Work Phone ________

Address ______________________________
(Directions)

Occupation: Father ____________ Mother ____________ Elementary School ____________

Household Composition (include ages)

Do both parents live in the home? ______ Do any other people live in the home? ______

---

1. Briefly describe you concerns about the child. (Onset, frequency, etc.)

2. In what way do you hope we can be of help to you?

3. What kind of help have you sought or received from other professionals or agencies? (Dates begun and ended; services provided; name and address)

4. Has the child attended a nursery school or daycare center? (Formerly, currently, future) (Director's name and telephone; days/times attended)

5. (If both parents work outside the home) - Who cares for your child during the day/night? (Name, address, telephone)

6. Who is the child's physician? Are there any medical problem? (Include Dr.'s address, telephone, specialty)

Home Visit:

EARLY CHILDHOOD PROGRAM

DEVELOPMENTAL HISTORY

Date ______________

Child's Name ______________________________ Birthdate ______________

Parent(s) Interviewed ______________________ Interviewed by ______________

I. PARENT'S STATEMENT OF PROBLEM

II. PREGNANCY AND BIRTH

1. How would you describe your pregnancy? (Different from other pregnancies? Prior miscarriages? Stillbirths? On any medication? Toxemia? Full term?)

2. Was there any difficulty during labor or delivery? (Anesthesia? Sedation?)

3. Birth Weigth ____________________ Length ______________________

4. What was the state of your child at birth? (Jaundice? Congenital abnormalities? Received oxygen? Resucitation? Any feeding difficulties?)

III. EARLY FEEDING AND BONDING EXPERIENCE

Describe early feeding experience. (Bottle? Breast?)

IV. DEVELOPMENTAL INFORMATION

1. Approximately when did your child do the following:

	Time	Concerns
Rolling over		
Sitting up		
Crawling		
Walking		

Toilet training: Begun ____________ Completed ____________

At present:	Urinary Continence	Bowel Control
	Day ________	Day ________
	Night ________	Night ________

2. Does your child seem to lose balance or fall down more than other children?

3. How does your child compare developmentally to other members of your family?

V. SPEECH AND LANGUAGE DEVELOPMENT

1. Do you have any concerns about your child's speech and language? (Parent comments and language samples)

2. When did you first become concerned about your child's language development?

V. SPEECH AND LANGUAGE DEVELOPMENT, continued

3. Approximately when did your child do the following:

Babble and coo ____________________ Did this every stop? ______
Say first meaningful word ____________________
Put 2-3 words together ____________________
Use complete sentences ____________________

4. Did your child ever stop talking at any stage? ____________________________

5. How much is your child understood by (% of time):

Family ______________ Playmates ______________ Strangers ______________

6. Does your child talk freely, frequently: At home _____ Away from home ______
If not, please explain.

7. How does your child react when people don't understand him/her?

8. How do you handle it when your child is not understood?

9. Have you tried anytning to correct the problem?

10. If your child does not use words, how does he/she communicate with you?

11. Has anyone in your family every had a problem with speech?

12. Has your child had frequent ear infections, colds, strep, since birth?

	Approximately how many	Treatment
1st year		
2nd year		
3rd year		
4th year		

13. Has his/her hearing ever been tested? If so, when? Where?

VI. FEEDING AND SELF-HELP

	Yes	No	Sometimes
1. Has child been weaned from bottle?			
2. Can child swallow without excessive choking/gaging?			
3. Can child chew effectively?			
4. Does he/she eat regular table food?			
If yes, when did he/she start?			
5. Can your child suck through a straw?			
6. Does he/she use a spoon without spilling?			

7. Was there any period of unusual weight gain/loss?

8. Does your child take off clothing independently? Examples.

9. Does your child put on clothing independently? Examples.

VII. HEALTH

1. Has your child had recurrent illnesses? Hospitalization? Explain.

2. Does your child have allergies to food, environment, animals? If so, to what? What is the allergic reaction?

3. Is your child on any type of medication? If so, what? When is it administered?

4. Has your child ever had a high fever or convulsions of any kind?

5. Is there a history of any disease in your family that is of concern to you? (i.e., kidney, blood disorders, heart disease, diabetes, rheumatic fever)

6. Has your child's vision been checked? Any suspected vision problems? Explain.

7. Do you have any other concerns about your child's health?

VIII. SOCIAL AND FAMILY

1. Do you have any concerns about your child's behavior? Yes ____ No ____
   If yes, when did you first become concerned?

2. Parent comments and interviewer observations:

3. How did this behavior affect the rest of the family?

4. Describe how your child interacts with other children, including nursery school experience.

5. Do you have any concerns about your child's behavior in any of these situations:

   Bedtime (specify hour): ____________________
   Mealtime: ____________________
   In public: ____________________

6. What form of discipline have you found effective with your child? Is this similar for the child's father/mother?

7. Have there been any unusual conditions in your family, like a death, divorce, illness, frequent moving, emotional stress, alcoholism?

8. If parents not living together, describe child's relationship with the absent parent.

9. List a few of the toys/activities your child enjoys.

10. What was your school experience like?

Appendix B-2

Naturalistic Observation of a "Typical" One Hour Assessment

1:05. The parent arrives with her 3-year old son, Jon. Jon has been referred to the ECH program for further evaluation because he failed the speech portion of the Denver. Jon is allowed to explore the room and familiarize himself with the surroundings as the staff introduces themselves to his mother.

1:10. The staff engages Jon in conversation in order to acquire a language sample. Jon is shy and clings to the mother, refusing to vocalize. The parent is encouraged to take out family photographs in order to motivate Jon to talk. Jon persists in crying and turning away, at which time the staff switches tactics. The pictures are put away and bristle blocks takenout.

1:20. Jon is contentedly sitting on his mother's lap playing with the blocks. The social worker arrives to do a case history with the mother. However, the mother is reluctant to leave her son because of his initial avoidance behavior. The staff is expressing some concern tha there will not be sufficient time to complete the evaluation. Therefore, a decision is made to allow the social worker to carry out the interview in the classroom, so that the mother can remain within the child's field of vision. Usually case histories are completed in the hallway outside the assessment classroom. The social worker agrees with the plan and proceeds with the parent interview.

1:30. Jon is sitting at the table with the speech pathologist and ECH teacher. He is contentedly describing picture stimuli show to him. Animal crackers and pegs are used as reinforcers. Meanwhile the staff is tape recording a language sample and recording speech and language errors.

1:50. One staff member meets with the parent to discuss their observations and findings. At this time possible options are discussed with the parent. A partial list of some of the options recommended directly following the one-hour assessment include the following:

1. No special education service
2. Closely monitoring child's development, but providing no special service at this time
3. Placement in the ECH program
4. Placement in a private nursery school which services handicapped preschoolers. The district is responsible for payment if the child is identified as having a handicapping condition.
5. Placement and monitoring in a regular nursery school.

It is made clear to the parent that these options merely present a realm of possibilities, not specific recommendations. The staff meets as a group (precompilation conference) prior to a second meeting with the parents to formalize the best options.

2:00. The one-hour assessment is completed.

Appendix B-3

EARLY CHILDHOOD PROGRAM
SCREENING REPORT

Name________________________________ Date of Screening______________

Birthdate__________________ Age ________

AREA: COMMUNICATION Is screening necessary in this area? ___yes ___no
If yes, screening tool(s) used________________

Concerns Noted by Early Childhood Staff:

A. ____Articulation of Speech Sounds

B. ____Expressive Language

C. ____Receptive Language

D. ____Fluency of Speech

E. ____Voice Quality

F. ____Language Use and Interaction

______Needs assessment ____Within normal range. No assessment necessary.

Comments:

Completed by__________________

AREA: COGNITION Is screening necessary in this area? ___yes ___no
If yes, screening tool(s) used________________

Concerns Noted by Early Childhood Staff:

A. ____Perceptual Discrimination-Ability to Discriminate the Features of Objects

B. ____Memory

C. ____Reasoning and Academic Skills

D. ____Conceptual Development - Ability to draw relationships, make comparisons, grasp concepts

______Needs assessment ____Within normal range. No assessment necessary.

Comments:

Completed by__________________

Name______________________________

AREA: SOCIAL-EMOTIONAL BEHAVIORAL

Is screening necessary in this area? ___yes ___no

If yes, screening tool(s) used________________

Concerns Noted by Early Childhood Staff:

A.___ Affective Response to Classroom
___separation
___early adjustment to school setting
___expression of feelings
___appropriate affect
___flat affect
___high anxiety
___preoccupied with negatives
___excessive crying
___listless/apathetic

B.___ Self Esteem
___avoidance/withdrawal
___willingness to try
___unsure of self

C.___ Response to Classroom
___transitions
___following routines/expectations
___attending-large/small group
___impulsivity
___disruptive
___easily excitable
___excessive activity
___denies responsibility for own actions

D.___ Use of Play Materials
___lacks variety
___lacks investment
___immature
___destructive
___ability to stay focused on activity

E.___ Relationship with Peers
___immature
___turn taking and sharing
___response to conflict
___asserting rights
___need to control/direct
___withdrawal/isolation
___empathy/sensitivity to others
___physical/verbal abuse toward

F.___ Relationship with Adults
___dependence
___physical/verbal abuse towards
___appropriate use of adults for nurturance, assistance, and information
___response to limits

________Needs assessment

____Within normal range. No assessment necessary.

Comments:

Completed by____________________

AREA: GROSS AND FINE MOTOR

Is screening necessary in this area? ___yes ___no

If yes, screening tool(s) used________________

Concerns Noted by Early Childhood Staff:

A.___ Gross Motor
___balance
___eye-hand coordination
___vestibular system
___motor planning
___muscle strength
___tactile system
___tracking

B.___ Fine Motor
___hand/foot dominance
___endurance during testing
___manipulative activities
___scissors and paper tasks
___pencil and paper tasks
___crossing the midline

________Needs assessment

____Within normal range. No assessment necessary.

Comments:

Completed by____________________

ASSESSMENT REPORT - DATE ________

Student's Name: ______________________ Parent's Name: ________________

D.O.B. & Age: ______________________ Address & Phone: (If different fro child's)

Student's Address: ______________________

Phone: ______________________

CONTENTS OF REPORT

I. Background Information - Social Work Report

II. Areas of Assessment: Attached Documents

A.

B.

C.

D.

III. Summary and Recommendations

Appendix B-4

ASSESSMENT OF SOCIAL/EMOTIONAL/BEHAVIORAL DEVELOPMENT

Name ______________________________ Date of Assessment ____________

Birthdate ________________ Age________ Completed by ________________

____ Social emotional development does not appear to demonstrate an educationally handicapping condition at this time. No significant concerns were observed.

____ Social emotional development appears to be an educationally handicapping condition at this time.

AREAS OF CONCERN NOTED BY EARLY CHILDHOOD STAFF:

A.___ Affective Response to Classroom

- ___separation
- ___early adjustment to school setting
- ___expression of feelings
- ___appropriate affect
- ___flat affect
- ___high anxiety
- ___preoccupied with negatives
- ___excessive crying
- ___listless/apathetic

B.___ Self Esteem

- ___avoidance/withdrawal
- ___willingness to try
- ___unsure of self

C.___ Response to Classroom

- ___transitions
- ___following routines/expectations
- ___attending-large/small group
- ___impulsivity
- ___disruptive
- ___easily excitable
- ___excessive activity
- ___denies responsibility for own actions

D.___ Use of Play Materials

- ___lacks variety
- ___lacks investment
- ___immature
- ___destructive
- ___ability to stay focused on activity

E.___ Relationship with Peers

- ___immature
- ___turn taking and sharing
- ___response to conflict
- ___asserting rights
- ___need to control/direct
- ___withdrawal/isolation
- ___empathy/sensitivity to others
- ___physical/verbal abuse toward

F.___ Relationship with Adults

- ___dependence
- ___physical/verbal abuse towards
- ___appropriate use of adults for nurturance, assistance, and information
- ___response to limits

AREAS OF CONCERN REPORTED BY PARENTS/GUARDIANS:

Name ______________________________ Date of Assessment _______________

Birthdate _________________________

SUMMARY:

RECOMMENDATIONS:

ECP STAFF COMPLETING ASSESSMENT REPORT:

Appendix B-5

PROCEDURE TO FOLLOW FOR ASSESSING 5-YEAR OLDS

A. 5-Year olds in Kindergarten:

Building team will assess and service.

If help is needed to complete assessment, ECP staff are available as consultants to instruct building staff in use of early developmental tests or observational techniques and tools.

If placement OUT OF KINDERGARTEN is being considered, fill out referral form I-B and send to Karen Filla.

B. 5-year olds not enrolled in Kindergarten:

Building team will begin the screening process:

- Telephone contacts with parents and other referring persons
- Obtaining any existing testing reports and developmental, medical data
- Involve ECP if needed
- Refer to PSS if not previously screened

After screening, decide who and where to do testing:

1. The building team should conduct the assessment if

   a. screening information suggests a serious or moderate developmental concern in only one area of development (e.g., motor or behavior or language).

   b. screening information suggests only mild concerns in two or more areas of development (e.g., articulation of speech sounds and motor delays).

   NOTE: While the team has an obligation to assess the child, the parents should be informed that service will be provided only if the child subsequently enrolls in kindergarten or qualifies for the ECP.

2. The ECP may be the most appropriate team to conduct the assessment if

   a. significant delays are suspected in two or more of the following areas of development: communication, learning, behavioral-emotional, or health-motor.

   b. the child has been serviced in an ECP in another district.

3. The Level IV classroom may be the most appropriate team to conduct the assessment if

   a. there is evidence of autistic like behaviors or retardation?

   b. it appears that a severe communication or behavioral disorder exists which another year in Early Childhood would be unlikely to correct.

Appendix B-6

A Partial Summary of the 1986 Transition Meeting (All names have been changed)

Thirty-five students were discussed at this meeting. The following information was presented on each child: (a) student's primary handicap, (b) secondary handicaps, (c) areas of need, (d) strengths, (d) recommendations, and (e) relevant issues affecting the decision-making process. All the data except recommendations had been collected apriori by teachers and therapists; this information was quickly read to the rest of the staff. The majority of time was spent achieving group consensus on recommendations for future programming and placement.

The entire Program B staff, including the teachers, speech therapists, occupational therapist, and social workers, was present. Some of the cases were simple. Others required a more in-depth exchange of ideas to reach consensus. Throughout the meeting the professionals appeared at ease in presenting their opinions, even when these conflicted with those presented by the coordinator. Overall, the line of authority in the meeting was difficult to determine, except when a definitive decision was made.

The following cases represent the students discussed in the first hour of the transition conference.

Time: 8:50

Name: Danny

Primary Handicap:

Other Handicaps:

Strengths:
- interaction skills with peers
- improved fine motor
- general knowledge
- age appropriate language form, use and speech sounds

Needs:
- foster more grown up behavior
- group attending skills - refocus attention on topic
  "We're talking about __________."

Recommendations:

Notes:
- consensus achieved quickly

Time: 8:55

Name: Steve

Primary Handicap: social/emotional behavior

Other Handicaps: motor, H.I.

Strengths:
- cooperative in classroom routines
- visual perceptual skills - social interaction with the most familiar adults in classroom
- eye/hand/finger coordination
- age appropriate form and structure of expressive language
- sensitivity to needs/feelings of others
- general knowledge - preacademic skills

Needs:

monitor hearing aid (hearing impaired program 287 will do and suggest ideas for good listening environment

increase social interaction with peers: reminder to answer kids when they speak to him; limit time spent in isolated play/facilitate play with peers

increase use of language: secure relationships with teachers, successful experiences to enhance self esteem, sufficient time to think and respond, along with expectation that he will respond

reduce sense of "performance anxiety": during individual focus at group time-opportunity to choose when he will have a turn (first, after Jason, etc.)

Recommendations:

kindergarten with screening for adaptive phy. ed. Re-evaluation for social-emotional behavior. Level II services from Program 287 Hearing Impaired

Notes:

Steve's teacher will need to know how to interact with Steve if he shuts down. An ED label will not serve his needs. A staf member asks, "Since Steve is already labeled ED do we demit him or let it ride?" A suggestion was made to re-evaluate the need for the ED label after Steve moves to the new setting.

Time: 9:02

Name: Martha

Primary Handicap: D.D. - Demit 5-7-86

Other Handicaps:

Strengths:

quick learner
enthusiastic about school
enjoys singing
improved attending skills
improved fine motor
attaches easily to adults/peers
improved vocabulary and comprehension
improved use of materials
improved sentence length
improved coping strategies

Needs:
language form - repetitions with peer models - possible individual treatment
impulsive in group - hard to wait turn: raise hand and wait turn
tries to take charge with peers: practice social communication in paired play, conversation. Remind Maitta it is teacher's job to direct the other children
medical monitoring by nurse - Maitta has Blount's Disease

Recommendations:
kindergarten, screen for possible Adpt. P.E.

Notes:
. The staff recommends summer school.
A decision is made to demit to a date for follow along and look at communication.
The staff recommends a summer school placement because Martha is progressing so rapidly but realizes that transportation may be a problem.

Time: 9:16

Name: Julie (probably moving this summer)

Primary Handicap: communication

Other Handicaps:

Strengths:
cooperative play skills
enjoys school
readiness skills
fine motor skills
willing to participate in all activities
liked by other children
increased independence

Needs:
improve speech sounds and language structures
home-school notebook with some practice activities
improve articulation using minimal-pair procedure
strategies to encourage thinking for himself (i.e., teacher not always telling Chad to do next, where to put his things, etc.)
increase willingness to take risks - try things on his own

Recommendations:
kindergarten - with Level III communication

Notes:
consensus reacted quickly

Time: 9:21

Name: Jimmy

Primary Handicap: communication

Other Handicaps:

Strengths:
fine motor skills
improved play skills/interactions with peers
complies with classroom rules and routines
liked by peers
willing to use teacher models and prompts
emerging self-help skills
shows pride in his accomplishments

Needs:
encouragement to take increasing responsibility for self clear, higher expectations
reflection on appropriate affect (facial expression), always smiles
gave prompts for verbal assertion
maturation of speech sounds
strategies to encourage thinking for himself (i.e., not telling him what to do next, where to put his things, etc.)

Recommendations:
nursery school (transitional kindergarten)

Notes:
Jimmy would not qualify for speech services if he was a new student. Therefore, should he be demitted from speech? He is so "taken care of that he cannot make any decisions on his own. Jimmy does not appear to be a learning problem according to the classroom teacher. "We may want to look at the EBD label." An EBD teacher has observed Jimmy at a private daycare and feels he stands out from his peers. The speech therapist reports that he should be demitted from speech because he has made so little progress. She feels he needs time to make developmental gains. The classroom teacher has seen some progress but does not feel he is ready for kindergarten. The personality of the teacher at the private special education nursery school was not felt to be appropriate for Jimmy. A final decision was made to demit Jimmy from speech and recommend a transitional kindergarten.

9:30 Following the discussion of Jimmy's needs, the conversation focused on when children should be demitted. The speech pathologist stated that the new setting wants the child demitted by the ECH program if the label is not longer appropriate. A recurring issue is whether the team can use IEP objectives to determine if a label can be dropped and a child demitted. The early childhood coordinator disagreed with the speech pathologist, stating that at this point, the ECH program should not be doing a lot of assessment for the elementary schools. She pointed out that each setting may do evaluations differently.

Time: 9:35

Name:

Primary Handicap: communication

Other Handicaps: only communication was assessed as specified by parents

Strengths:
friendly
age appropriate one word vocabulary
high intent to communicate
curious, inquisitive

Needs:
- improve articulation and language structures
- establish attention to speaker and staying on topic
- establish reciprocal style of interaction (turntaking)
- vestibular stimulation and confinement to net swing to help focus attention and decrease teacher's management of interfering physical behavior

Recommendations:
- level III speech

Notes:
- consensus reached quickly

Time: 9:44

Name: Jeff

Primary Handicap: social-emotional/behavior

Other Handicaps: early childhood special education

Strengths:
- average intellectual ability
- responsive to 1:1 adult attention
- language/vocabulary
- imaginative play
- independence

Needs:
- improve ability to use classroom effectively for learning: clear expectations and consequences, soft verbal reminders for appropriate behavior before misbehavior occurs, nonverbal reminders (sitting near teacher, eye contact), provide choices, needs ways to keep active to prevent inappropriate behaviors
- increase ability to internally control behavior (initial) system of concrete rewards for appropriate behavior, explanation/reasoning for appropriate behaviors/consequences of inappropiate behaviors
- improve adult relationships: consistent positive relationships with teacher during initial "testing," self esteem building praise

Recommendations:
- kindergarten with EBD services

Notes:

Jeff's early childhood special education label will have to be re-evaluated in the new school because kindergarten is not an appropriate option for a child with this label. The staff is concerned that if the label is dropped - this will imply that the child does not have needs. On the other hand, they do not want to be forced to label under the elementary system. The label of ECH can only be applied until age seven if an ECH licensed person is teaching the child.

Time: 9:53

Name:

Primary Handicap: emotional behavioral

Other Handicaps: communication

Strengths:

general knowledge and comprehension
curious learner
improvement in social interaction skills with peers and adults
responds to behavioral management strategies
increased ability to use classroom independently

Needs:

limit excessive verbal rationalizations
rephrasing task refusal and "I'm too tired" statements into statements about task difficulty, "This is hard. You can still try."
establishing role boundaries (adult jobs, children's jobs) to decrease controlling and manipulative behaviors
support in fine motor skills
monitor spech intelligibility in classroom, to determine whether or not more speech intervention is needed

Recommendations:

kindergarten, level II communication, adaptive physical education

Notes:

consensus reached quickly

Appendix B-7

Yearly Procedures (Working Draft)

A. WORKSHOP WEEK

1. Phone parents to verify fall assessment schedule.	S
2. Prepare forms for fall assessment group as needed.	Classroom
a. Student Special Needs Referral (Form 1)	
b. Assessment Permission (Form 2)	
c. Release of Information (Form F)	
d. Burks' Behavior Rating Scale	
e. Transportation Form	
f. Classroom Observation Form	
g. Play Data Form	
3. Establish yearly calendar.	Team
4. Revise ECP Handbook.	Team
5. List assessment/re-evaluation areas.	Classroom
6. Plan activities/objectives for fall group assessment.	Classroom
7. Complete home visits on new referrals.	Social Workers
8. Purchase snacks/order snack supplies from elementary school.	Classroom
9. Sign up for gym time.	

B. FALL CLASSROOM ASSESSMENT

1. Get parent signatures on Forms 1, 2, and F as needed.	Classroom
2. Send home Burks' for completion as needed.	Classroom
3. Send home transportation information form.	Classroom
4. Do individual testing as appropriate (especially for cases requiring manys tandardized tests to determine eligibility).	Classroom
5. Determine need for individual assessment times.	Classroom
6. Schedule individual assessment times.	Classroom
7. Schedule assessment conference times.	Classroom
8. Send conference notices (2c)	Classroom
9. Kindergarten Transition Followup: Contact teachers.	Classroom

C. FALL INDIVIDUAL ASSESSMENT

1. Complete standardized testing.	Classroom
2. Compile data for each child; determine eligibility.	Classroom
3. Kindergarten Transition Follow-up: Visit K. classrooms, consult with staff.	As assigned

D. STAFF CONFERENCE/REPORT WRITING

1. Debrief information; determine eligibility.	Team
2. Complete forms;	
Original Assessment Compilation (2A)	Case Manager
ECP Assessment Report	Case Manager
IEP Plan (3, Part 1)	S + Case Mgr.
Welcome letter	Case Manager
3. Begin IEP Goals and Objectives (3, Part 2).	Classroom
4. Confirm transportation.	S
5. Assemble forms needed for conferencing.	Team

E. FALL PARENT ASSESSMENT CONFERENCE

1. Discuss assessment results.	Case Manager
2. Get parent signatures.	Case Manager
a. Original Assessment Compilation	
b. IEP Plan (3 Part 1)	
3. Distribute information.	Case Manager
a. Welcome letter	Classroom
b. Immunization Form	
c. Emergency card	
d. Blanket permission slip	
e. ECP Handbook	
f. Transportation information	
4. Discuss IEP Goals and Objectives (Form 3, Part 2).	Team
5. Discuss parent participation options.	Team
6. Debrief conferences.	Team

F. ENTER DATA ON ASSIST SYSTEMS

F. ENTER DATA ON ASSIST SYSTEMS	Secretary

G. NOVEMBER/DECEMBER PARENT CONFERENCE

1. Discuss assessment report.	Team
2. Get parent signature for Original Assessment. Compilation (2A) cum forlder inclusion	Case Manager
3. Distribute IEP Goals and Objectives (Form 3, Part 2).	Case Manager

PROPOSED ASSESSMENT PROCEDURES AND SCHEDULES

II. Spring (1985-86)

Last day class	May 8	
Picnic	May 8	
"Wind Down"	May 9	
Schedule screening	May 12	
Transition conference with elementary staff	May 13	
Screening	May 14, 15	
Planning assessment	May 16	
Assessment - 2 weeks	May 19-22 May 27-30	Speech & O.T. staff test & compile 23-30. See fall schedule for procedural description
Analyze data, write reports	June 2-5	
Compilation	June 6	
Complete reports	June 9, 10	
Parent conferences	June 11, 12	

Appendix C-1

COMMUNICATION ABILITIES QUESTIONNAIRE

Preliminary Information

Child's Name ______________________ Child's Birthdate __________

Informant's Name ______________________ Today's Date __________

Informant's Relationship to Child: (Check One) Mother ________ Guardian ________

Father ________ Other ________ Please Specify

School District/Agency

I have consulted a speech and language specialist about my child's speech and/or language development.

Yes ______ No ______

My child is now receiving special help from a speech and language specialist.

Yes ______ No ______

My child has received special help from a speech and language specialist at some time in the past.

Yes ______ No ______

To Parent(s)/Informant

Your special knowledge of your child provides important information about your child's communication development that cannot be obtained through tests. The Communication Abilities Questionnaire is a means of using the information that only you can provide to get a picture of your child's communication development. It is therefore important that you follow these instructions carefully.

Instructions

Please answer each question as it applies to your above named child. It is very important that you answer every question. Do not skip any of the questions!

You will see a statement about some aspect of your child's communication ability. Under that statement appear the numbers 1 through 6, representing a range of ability. Check the number that best describes your child's ability.

Example

My child can be understood over the telephone.

Completely unintelligible 1 ____ 2 ____ 3 ____ 4 ____ 5 ✓ 6 ____ Completely intelligible

If, for example, you believe that your child's speech is mostly, but not completely intelligible over the telephone, you might check the 5 to indicate this.

Now go on to the next page and begin answering the questions.

1. Friends and/or relatives have commented that it is difficult to understand my child when (s)he talks.

Often 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Never

2. I am concerned that my child's speech and/or language is slow in developing.

Extremely concerned 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Not at all concerned

3. My child's speech and language behavior is:

Much less adequate than children of same age 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Much better than children of same age

4. My child should by checked by a speech and language specialist.

Strongly agree 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Strongly disagree

5. I've thought about getting professional speech help for my child.

Very often 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Never

6. In thinking about the amount of talking my child does, I would say that (s)he talks:

Much less than children of same age 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Much more than children of same age

7. It's an effort for my child to talk.

Extreme effort apparent 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ No effort apparent

8. My child's speech can be understood by strangers.

Never understood 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Always understood

9. My child can be understood over the telephone

Completely unintelligible 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Completely intelligible

10. My child talks too fast to be understood.

Always 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Never

11. I understand what my child says.

Never understand 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Always understand

12. Other children tease my child about the way (s)he talks.

Very frequently 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Never

13. My child's pronunciation of words is clear.

No words are clear 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ All words are clear

14. My child has difficulty making and using many speech sounds.

Strongly agree 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Strongly disagree

15. My child pronounces the /k/ sound, as in "cookie," correctly.

Never 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Always

16. My child pronounces the /g/ sound, as in "good," correctly.

Never 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Always

17. My child pronounces the /d/ sound, as in "dog," correctly.

Never 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Always

18. My child pronounces the /f/ sound, as in "finger," correctly.

Never 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Always

19. My child's overall speech sound production is:

Much less adequate than children of same age 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Much better than children of same age

20. My child leaves sounds out of words when (s)he talks. (Examples: "ca" for "cat" or "i cream" for "ice cream")

Always 1 ______ 2 ______ 3 ______ 4 ______ 5 ______ 6 ______ Never

Go on to the next page

21. I would rate my child's speech fluency (smoothness and ease of talking) as:

Much less adequate than children the same age 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Much better than children the same age

22. My child repeats the first sounds of words over and over.

Very frequently 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

23. My child repeats the first part of a word over and over.

Very frequently 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

24. My child repeats small words over and over.

Very frequently 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

25. My child stutters. (How?)

Very severely 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Not at all

26. My child stutters. (How often?)

Very frequently 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

27. My child repeats syllables — "I see the ba-ba-ba-baby."

Very frequently 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

28. My child prolongs sounds — "I sssssssee the baby."

Very frequently 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

29. My child has difficulty getting his/her words out. (How often?)

Very frequently 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

30. My child has difficulty getting his/her words out. (How much effort?)

Extreme effort apparent 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ No effort apparent

on to the next page

31. My child's voice is pleasant to listen to.

Strongly disagree 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Strongly agree

32. My child sounds as though (s)he is talking through his/her nose.

Extremely noticeable 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Not at all noticeable

33. My child sounds like (s)he has a frog in his/her throat.

Extremely noticeable 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Not at all noticeable

34. My child's voice is too loud or too soft.

Always 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

35. My child's voice is too high pitched or low pitched.

Extremely noticeable 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Not at all noticeable

36. My child's voice is excessively nasal.

Extremely noticeable 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Not at all noticeable

37. My child's voice is excessively hoarse or harsh.

Always 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never

38. My child's oral language (vocabulary, grammar, ability to tell experiences) is:

Much less adequate than children of same age 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Much better than children of same age

39. My child can tell his/her first and last name without help.

Never 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Always

40. My child can give simple accounts of experiences in understandable sentences and in proper order without help.

Much less adequately than children of same age 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Much better than children of same age

Go on to the next page

41 My child can name colors (red, yellow, blue) correctly when shown toys or crayons of different colors

Never accurate 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Consistently accurate

42 My child puts together sentences of two or more words.

Never 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Most of the time

43 My child uses pronouns incorrectly; for example, says "Her goes to the store" for "She goes to the store."

Always incorrect 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Never incorrect

44 My child speaks one or two words at a time and rarely uses complete sentences

Strongly agree 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Strongly disagree

45 My child's ability to understand and remember what is said is

Much less adequate than children of same age 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Much better than children of same age

46 My child can follow directions which contain words such as "on," "in," "under" and "next to" correctly

Never 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Always

47 My child can remember and carry out a sequence of three instructions in the right order

Never 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Always

48 My child enjoys listening to stories

Not at all 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Very much

49 My child can follow directions

Much less adequately than children of same age 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____

50 My child can identify objects and actions in pictures

Much less adequately than children of same age 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ Much better than children of same age

Thank you for completing the questionnaire!

This project is supported by funds from the Minnesota State Department of Education and the Bryng Bryngelson Communication Disorders Research Fund, University of Minnesota.

Appendix C-2

Date: ____________________

PRESCHOOL REFERRAL FORM

Student ______________________________ Age ____ Date of Birth ______________

Parent/Guardian ______________________ Address ____________________________

Phone: Res. ______________ Work ______________ Home School ______________

Foster Home? _____ If a foster home, indicate below the name and address of the natural parent(s) of the above child, as well as the name of the school district where said parents reside.

Name of Natural Parent(s) ______________________ Phone ______________

Address of Natural Parent(s) ____

School District Name & No. ____

If Dept. of Welfare involved, name and phone of social wkr. ______________

(Indicate county, state, or spec. agency ________________ Phone ____________

Referral Source ____

Referral Concerns ____

DIAL-R Results: Cut off score for age/sex _____. Score Obtained ______________

Motor ______________, Concepts ______________, Language ______________

Not Administered ______________.

Significant information from "Comprehensive Child History" form or referring agent: ____

List previous interventions: ____

Reports requested from other agency:

Agency ______________________________ Date Requested ______________

Agency ______________________________ Date Requested ______________

Referred for Assessment: Yes ____ No ____

Areas to be assessed:

Cognitive ____
Fine Motor ____
Gross Motor ____

Speech ____
Language ____
Health ____

Hearing ____
Social/Emotional/Self Help ____
Readiness ____
Other ____

Comments: ____

5/85

Appendix C-5

CS-4
Revised 6/85

Check

____parent/legal guardian notice
____resident district notice
____foster parent notice

NOTICE OF SCHEDULED CHILD STUDY TEAM CONFERENCE

Date________________

Dear______________________________,

You are invited to participate in a team conference regarding ______________________. The purpose of the meeting is to:

____discuss assessment/reassessment results;
____review progress and possible program modifications;
____other______________________________________.

Day/Date__________________________
Time___ __________________________
School____________________________
Location in school________________
Confirmed via telephone_________by______________

We encourage you to attend and assist us in developing an appropriate educational plan. If you are unable to attend, the team conference will take place as scheduled and a copy of the conference results will be mailed to you.

If you have further questions or you find this time to be inconvenient, please call______________________at___________________________.

Sincerely,

____
Principal or designee

____
Title

The following persons have been invited to the conference:

Principal______________________________
Parents________________________________
Classroom Teachers_____________________
____
____
Counselor/Social Worker________________
Basic Skills Specialist________________
School Nurse___________________________
Speech Clinician_______________________
School Psychologist____________________
Chapter I Teacher______________________
Occupational Therapist_________________
Other__________________________________
____

WHITE - Child Study File   **YELLOW** - Parent/resident district/ foster parent

Appendix C-6

Form CS - 6
Revised 6/83

INDIVIDUAL EDUCATIONAL PLAN (IEP)

Date of Conference____________

Student______________________ Birthdate__/__/__ Age_____ Grade____
mo day yr

School______________________ Teacher/Counselor______________________

Parent/Guardian______________________ Address______________________

Telephone: Home__________ Work__________ ______________________
Zip Code

Child Study Team Participants:

Principal______________________ Special Education Teacher(s)______________

Parents______________________ ______________________

Classroom Teacher(s)______________________ Reading Specialist ______________

______________________ School Nurse______________________

______________________ Speech Clinician______________________

______________________ School Psychologist______________________

______________________ Chapter I______________________

Counselor______________________ Other______________________

Based on the assessment, the following strengths and weaknesses have been identified, and as a result the educational needs have been determined.

Strengths	Weaknesses	Needs

Special Education Services	Service Level	Anticipated Beginning Date	Amount of time per week	Estimated Duration	Location/ School Phone	Person(s) Providing Service

Related Service(s)

WHITE - Parent sign and return - CS File
YELLOW - Parent
PINK - Specialist
GOLDEN ROD - Classroom Teacher

Based on the principle of providing services with the least restrictive alternative, explain why this program and service level are most appropriate to meet this student's educational needs:

____

____

____

The following adjustments are recommended in order to implement the student's program:

Personnel:______________________ Facilities:______________________

Transportation:______________________ Equipment:______________________

Describe the educational activities and involvement this student will have in the regular mainstream program ONLY when the student's primary placement is in a special educational program.

____

____

Annual Goals:

Anticipated review dates of objectives:__/__/__ and __/__/__.
mo day yr mo day yr

______________________ ______________________
Principal or Designee/Date Special Education Designee/Date

Parent/Guardian Response:

Please check one of the statements below, sign and date. Your parental rights are attached. (Note item G)

A. ( ) I give permission for the district to proceed with the placement as proposed in the Individual Education Program plan.

B. ( ) I do not understand why this placement is needed for my child. Please contact me to schedule a private conference to discuss the reasons for the proposed placement.

C. ( ) I do not give permission for the district to proceed with the placement as proposed in the special education program plan, and request a conciliation conference with the district. I understand this conference will take place within 10 school days after the school receives this form and that you will contact me to arrange a mutually agreeable time and place.

Signature______________________ Date______________

WHITE - Parent sign and return - CS File
YELLOW - Parent
PINK - Specialist
GOLDEN ROD - Classroom Teacher

INDIVIDUAL EDUCATIONAL PROGRAM PLAN

Student________________________ School______________ Grade______

Program______________________ Person Responsible______________

Date______________

Annual/Periodic Review

Review Date____________________

Goal Area	Short Term Objectives and Criteria	
	Student will: Date begun:______________ Curriculum, materials, methods:____________________	☐ Mastered ☐ Discontinued ☐ Continued (Current performance__________) ☐ Altered/modified (Revision:__________) Comments:
	Student will: Date begun:______________ Curriculum, materials, methods:____________________	☐ Mastered ☐ Discontinued ☐ Continued (Current performance__________) ☐ Altered/modified (Revision:__________) Comments:
	Student will: Date begun: Curriculum, materials, methods:____________________	☐ Mastered ☐ Discontinued ☐ Continued (Current performance__________) ☐ Altered/modified (Revision:__________) Comments:
	Student will: Date begun:______________ Curriculum, materials, methods:____________________	☐ Mastered ☐ Discontinued ☐ Continued (Current performance__________) ☐ Altered/modified (Revision:__________) Comments:
	Student will: Date begun:______________ Curriculum, materials, methods:____________________	☐ Mastered ☐ Discontinued ☐ Continued (Current performance__________) ☐ Altered/modified (Revision:__________) Comments:

White - CS File   Yellow - Parent   Pink - Specialist   Goldenrod - Classroom Teacher

Appendix C-7

Program C

Diagnostic Assessment

PARENT SUMMARY SHEET OF TEST INFORMATION

Speech/Language	Strengths	Weaknesses
____tested		
____not tested		
	Recommendations	

Occupational Therapy (fine and gross motor)	Strengths	Weaknesses
____tested		
____not tested		
	Recommendations	

Readiness	Strengths	Weaknesses
____tested		
____not tested		
	Recommendations	

Intelligence	Strengths	Weaknesses
____tested		
____not tested		
	Recommendations	

Social/Emotional/Behavior **Strengths** **Weaknesses**

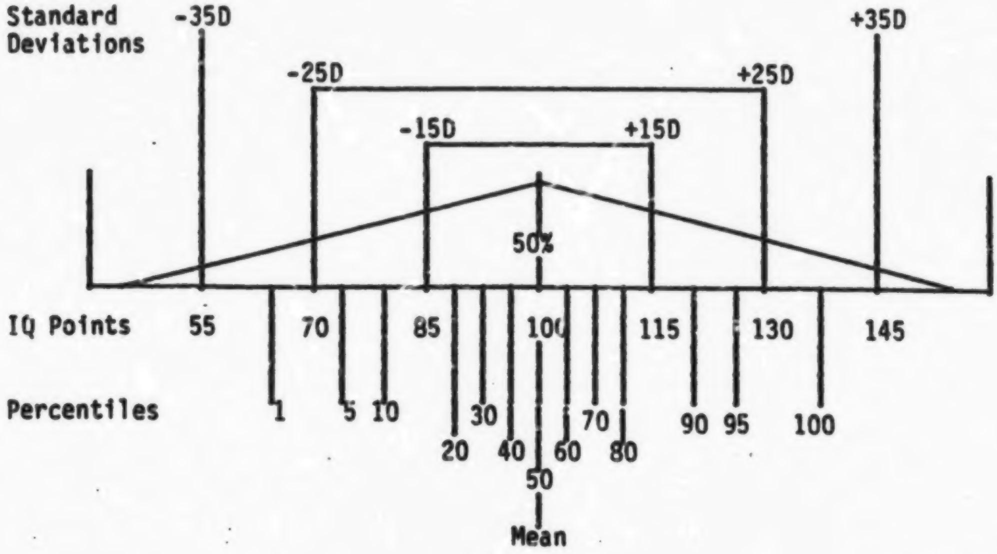
_____tested

____not tested

Recommendations

Parent Information **Strengths** **Weaknesses**

General Comments/Suggestions



Revised 3/86

Appendix C-8

Program C Criteria

TERMINOLOGY

Early Special Education (ESE)

DEFINITION

ESE shall be available to those children birth to seven years of age who need special instruction or services because they are visually, auditorially, physically or other health impaired; are emotionally/behaviorally disordered; have an identifiable syndrome known to hinder normal development; or have a significant delay or impairment in cognitive, speech or language development.

ENTRANCE CRITERIA

A child is eligible for ESE if she/he is between the ages of birth and seven years and has a significant delay which is verified by an assessment using an appropriate, standardized norm-referenced instrument which shows functioning at least 1.5 standard deviations below the mean (at or below the 7th percentile) and supported by documented, systematic observation in the following disability/program areas:

> speech, language, hearing impaired, visually handicapped, mentally handicapped, emotionally/behaviorally disordered, physically or other health impaired, autism, deaf-blind, cognitive development.

APPROPRIATE SERVICE AND PLACEMENT REQUIREMENTS

If a child has a speech handicap only, she/he shall be served by a speech/language clinician.

If a child has an expressive language handicap only, she/he shall be served by a speech/language clinician. If both expressive and receptive language are significantly delayed or if there are significant motor speech problems combined with an expressive language disorder she/he shall be served in the ESE program.

If the child is hearing impaired or visually handicapped only, she/he may be served by the categorical teacher with consultation from the ESE teacher or vice versa.

If the child has a severe fine and/or gross motor delay and is not medically diagnosed, the child shall receive occupational therapy (OT) or adaptive physical education (APE) only if she/he meets the criteria for these services and the criteria for another handicapping condition and is in ESE, i.e., OT and APE are related services.

If the child has a severe fine and/or gross motor delay and is medically diagnosed, the child may receive either OT or APE but usually not both.

If the child is identified as having an identifiable syndrome known to hinder normal development and does not meet the entrance criteria above, she/he may be served using a home-based or indirect/consultation ESE program alternative.

Children birth through four years of age, who qualify in any of the disability areas (other than speech, language, hearing impaired, visually handicapped) must be served by a special education early childhood teacher with appropriate consultation whenever necessary.

(over)

A SIGNIFICANT CHANGE IN THE PROGRAM IS INDICATED WHEN:

1. The data demonstrates documented lack of progress in the achievement of IEP goals and objectives requiring an addition to or change in the special instruction and related services to be provided; or

2. (a) the data demonstrates documented progress in the achievement of IEP goals and objectives, and

   (b) the student demonstrates, during a predetermined trial period, the ability to function and progress adequately with a reduced amount of special education and/or related services.

EXIT CRITERIA

1. When data documents that the child has: (a) achieved all IEP goals and objectives, and (b) demonstrated through systematic observation during a predetermined trial period, the ability to function in his/her non-special education environment without the provision of special education instructions and related services; or

2. when the child can more appropriately be served in another special education program or setting; or

3. when the child has reached age seven by September 1, unless a program variance has been obtained from the Special Education Section of the Minnesota Department of Education.

Appendix C-9

An Addendum to the IEP

In order to assist your child in developing and enhancing their social/emotional behavior a social skills/friendship group has been initiated in their program. The group meets for approximately twenty minutes three times a week and is conducted twice a week by their teachers and once a week with the psychologist

The primary goal for this group is to develop your child's communication skills and social competence so they can more effectively interact with others in their environment. Through the use of discussion, modeling and role playing we hope to facilitate this process.

The following objectives have been established:

1. Improve classroom survival skills
   e.g., listening, asking questions, saying please, thank you and following instructions
2. Develop friendship-making skills
   e.g., introducing self, joining in, offering help, sharing, apologizing
3. Develop skills for dealing with feelings
   e.g., expressing feelings, recognizing others' feelings, dealing with anger and fear, expressing affection
4. Develop skills alternatives for aggression
   e.g., asking permission, responding to teasing, staying out of fights, problem solving
5. Develop skills for dealing with stress
   e.g., making a complaint, dealing with losing, dealing with being left out, accepting no.

Appendix C-10

An Addendum to the IEP

Beginning date ____________________

Child's name ______________________

In order to provide your child with the least restrictive program and to develop school readiness skills, mainstreaming activities will be offered through the Early Childhood Family Education program. This curriculum covers the following areas of development:

1. large and small muscle activities
2. dramatic play
3. cognitive/readiness skills
4. socialization skills

The possible program options for you and your child are listed below:

1. Parent/child/teacher interaction in classroom
2. Parent groups
3. Child/teacher in classroom

The amount of time your child will spend in the mainstream classroom will be 1-2 hours per week.

APPENDIX D-1

EARLY CHILDHOOD:SPECIAL EDUCATION

1. DEFINITION

1.1. Early childhood:Special Education (EC:SE) shall be available to those children between the ages of four (4) and seven (7) who are in need of special education instruction or services because they have a significant delay visually, auditorily, physically, or other health impaired; are emotionally/behavioral disordered; have an identifiable syndrome known to hinder normal development; or have a significant delay or impairment in cognitive or language development.

1.2. EC:SE services are permissable for children 0 through 3 years of age.

2. SCREENING GUIDELINES

2.1. Children between the ages of 3 1/2 and 4 1/2 are routinely screened for potential EC:SE.
  a. Yearly Preschool Screening clinics are offered through each school district.
  b. Children missing the Preschool Screening clinics "or" those children in need of a developmental screening for any reason may be assessed at any time.

2.2. Guidelines for Determining the Need for Assessment Following Screening.
  a. Assessments will be completed on students whose rescreening scores fall below the cut off points in two or more of the following areas: fine motor, concepts or communications.
  b. Behavior referrals will be generated based on a behavioral checklist to be completed during Preschool Screening.

3. SST REFERRAL PROCEDURE

3.1. A systematic process is used within the regular education setting to determine whether a student needs to be considered for alternative services, including referral for a comprehensive child study assessment.
  a. Results of any screening procedures used—general testing, checklists, screening instruments.
  b. Review and documentation of educational and health records to note:
    1. Current vision and hearing screening results, (Referral is made to appropriate specialists when screening tests are failed or if physical or medical problems are suspected.)
    2. health history, (Referral is made to appropriate specialists when screening tests are failed or if physical or medical problems are suspected.)
    3. family mobility patterns,
    4. language used in the home,
    5. previous referrals and/or placements
  c. Review and/or observation of student's functioning level:
    1. All ability and/or achievement testing results,
    2. The student's functioning level (if known) in the following areas, i.e., speech/language, fine motor, gross motor, prekindergarten concepts, behavior.

3.2. When there is a reasonable basis for believing a student has a handicap in need of special education the student should be referred

3.3. If there is not a reasonable basis for such a referral, the referring person should consult with other professionals and resource persons in the district.

3.4. All referrals for special education should be reviewed (screened) by the SST to insure (a) the referral is complete and (b) the reason(s) for referral concisely describe the academic, behavioral, social, ability and/or other areas in need of assessment.

4. REQUIRED ASSESSMENT DATA

4.1. Diagnostic assessment

a. Results obtained from Section Three above.
b. Diagnostic assessments shall be given to identify problems in the areas of speech/language, fine motor, gross motor, behavior, and pre-academic.
c. Cognitive assessment shall be given as appropriate to child's handicap.

5. ANALYZING DATA FOR EDUCATIONAL DECISIONS

5.1. The data indicates eligibility in any one of the following disability program areas: Language, Hearing Impaired, Visually Handicapped, Mentally Handicapped, Emotionally/Behavior Disordered, Physical or Other Health Impaired, Autism, Deaf-Blind, Learning Disability, or Adaptive Physical Education.
Note: The Identification of a preschool age child as having specific learning disabilities is a questionable practice. The current definitions and criteria are not applicable to children who have not received instruction in the basic skill areas.

OR

5.2. The data indicates a Developmental or Cognitive delay that is verified by an assessment using an appropriate, standardized norm-referenced instrument which shows the child to be functioning at least 1.5 standard deviations below the mean and can be supported by systematic observation.

OR

5.3. The child has an identifiable syndrome know to hinder normal child development.

5.4. If a child has an identifiable syndrome know to hinder normal development but does not meet the criteria in 1 or 2 above, she/he shall be served using indirect consultation through an EC:SE program alternative.

5.5. Use Early Childhood:Special Education Eligibility Verification Form.

6. PROGRAM CHANGE AND EXIT CRITERIA

6.1. The team after reviewing data collected over a predetermined period of time to document the progress made in academic and other IEP goals/objectives (observation, assessment results, reports, etc.) may propose:

a. A significant change in the program which:
   1. necessitates the addition or change/modification of special education instruction and/or related services because the data demonstrates documented lack of progress in the achievement of IEP goals and objectives; or
   2. allows the reduction of special education instruction and/or related services because (1) the data demonstrates documented progress in the achievement of IEP goals and objectives, and (2) demonstrates, during a predetermined trial period, the student's ability to function and progress adequately with the reduced amount of special education and/or related services.

b. Exit (termination) from special education:
   1. when data documents that (1) the student has achieved all IEP goals and objectives, and (2) demonstrated, during a predetermined trial period, the ability to function in regular education programs without the direct provision of special education instruction and/or related services;
   2. when the student has completed a secondary program and is eligible to graduate;
   3. when the student exceeds school age, i.e., 21.

IV. PRIORITIES AND DIRECTION

Program Functions

A. To provide quality educational programs and services for students to assist educational units in the exploration, development, evaluation, and maintenance of program and services which meet the educational needs of students:

1. To assist school personnel, parents and community agencies in providing appropriate programming for students through evaluation, consultations and demonstration teaching relating to individual students.
2. Provide remedial and/or developmental instruction to individual students requiring services.
3. Provide for the improvement of programs, services and instruction offered to students through inservice training of all necessary personnel.
4. Assist in the design, planning and necessary consultation for improvement and implementation of programs provided by the educational unit.
5. Identify students, through group assessment and screening procedures having conditions that would qualify for appropriate special services and instruction.
6. Provide for student and professional learning through preparation and selection of media and materials.

B. To provide and assist educational units in programming for students through budgetary, management information, program planning and financial assistance.

1. Assist in the planning, pupil accounting and approval of local programs, personnel and equipment for reimbursement of federal, state and other financial aid.
2. To interpret and enforce appropriate chapters in the State Code, Department of Education, regulations and local policies relating to education.
3. To provide for a financial budget, inventory and property accounting designed to meet the identified needs of students in the school districts served by the cooperative.
4. To provide an on-going program planning evaluation effort to determine the need for and effectiveness of services.

C. To provide for the improvement and coordination of professional services offered by the cooperative and Districts.

1. Initiate and maintain liaison services with educational and noneducational organizations providing services for students.
2. To insure continuity and coordination of programs, provide for intra-office communication and relations with other educational programs providing services for students.
3. To insure the application of current educational practice, provide for continuing education through development of staff competencies.
4. Provide professional and educational materials by ordering, receiving and maintaining such material as cooperative educational resource materials.
5. Foster professional and public understanding of education by disseminating information relating to services through all necessary media.
6. To promote legislation and policies based on identified needs to insure quality education for students.
7. To provide program continuity and quality service through recruiting of qualified personnel.

APPENDIX D-2

FORM XI - Page 1 - 7/85

EARLY EDUCATION:SPECIAL EDUCATION ELIGIBILITY VERIFICATION

1. Demographic Data: DATE COMPLETED________________________

1.1. Student______________________________

2. Eligibility Verification:

2.1. Assessment Data

* a. Data indicates eligibility in one or more of the following areas (check as appropriate):

____ Language/Communication

____ Hearing Impaired

____ Visually Impaired

____ Mentally Retarded

____ Emotional/Behavior Disordered

____ Physically Handicapped

____ Other Health Impaired

OR

b. Data indicates a developmental or cognitive delay (check as appropriate):

____ Cognitive delay is 1.5 standard deviation below the mean

____ Developmental delay is 1.5 standard deviation below the mean

OR

c. Child has an identifiable syndrome known to hinder child development:

_____ Yes

_____ No

2.2. Additional Documented Data the Assessment Team Feels is Relevant to Eligibility Criteria.

a.

b.

c.

2.3. Student Meets Eligiblity Criteria Based on Documented Data from Sections 2.1.a., 2.1.b., 2.1.c., or 2.2.

a. _____ Yes
b. _____ No

* Attach a copy of the appropriate disability eligibility verification.

APPENDIX D-3

Sample Program D Morning Schedule

Wednesday, March 19, 1986

8:00 - 8:25	Free Play
8:25 - 8:30	Bathroom Break
8:30 - 8:45	Calendar, Sharing
8:45 - 9:30	Language Activity
9:30 - 9:50	Milk Break, Story
9:50 - 10:20	Music
10:20 - 11:00	Work Groups
11:00 - 11:10	Reward Time
11:10 - 11:25	Gross Motor
11:25 - 11:30	Wash-up
11:30 - 12:00	Lunch
12:00 - 12:15	Quiet Play
12:15 - 12:30	Fine Motor Activity
12:30 - 12:40	Story, Prepare for naps
12:40 - 1:30	Naptime
1:30 - 1:45	Quiet Play, puzzles, books, etc
*1:45 - 2:30	Stations (Fine Motor, Cognitive, etc.) *Children are pulled out for adaptive physical education at this time
2:30 - 2:40	Get ready for dismissal -- varied times for departures, depending on where the child lives

APPENDIX D-4

FORM V - Page 1 - 7/85

INDIVIDUALIZED EDUCATION PLAN

1. **Demographic Data:** DATE COMPLETED________________

1.1. Student________________ 1.6. Building Location________________

1.2. Birthdate________________ 1.7. District________________

1.3. Age________________ 1.8. Parent/Guardian________________

1.4. Sex________________ 1.9. Address________________

1.5. Grade________________ ________________

1.10. Phone________________

1.11. Referred by________________

2. **I.E.P. Staffing Team:**

2.1. Name	Position
________________	Parent/Guardian
________________	Student
________________	District Representative
________________	Educational Specialist
________________	Classroom Teacher
________________	________________

3. **Periodic Review:**

3.1. The Next Periodic Review Will be Held______(tentative date) at ________________(location) Unless a Request is Made for a Review at an Earlier Time.

4. **Type of Special Education Service(s) Provided:**

	Service	Level	Start Date
4.1.	________________	________________	________________
4.2.	________________	________________	________________
4.3.	________________	________________	________________
4.4.	________________	________________	________________
4.5	________________	________________	________________
4.6.	________________	________________	________________

5. Assessment Results and Indicated Student Strengths and Needs:

5.1.

5.2.

5.3.

5.4.

5.5.

5.6.

6. Location of Services if other than School Attending

7. Based on the Principle of the Least Restrictive Alternative, the Following Reasons are Given to Substantiate why this Plan is Most Appropriate to Meet this Student's Needs.

7.1.

7.2.

7.3.

7.4.

8. The following Changes will be Made to Accommodate and Educate the Student in the Least Restrictive Alternative.

8.1. Staff:

8.2. Facilities:

8.3. Transportation:

8.4. Curriculum/Methods:

8.5. Materials/Equipment:

8.6. Other:

9. Activities with Non-Handicapped for Students with Primary Placement in Special Education Programs.

9.1.

9.2.

9.3.

9.4.

10. Parental Rights Review

10.1. Date_______________

11. Parental/Guardian Response

11.1. ______ I/we do agree to the Individualized Education Plan.

11.2. ______ I/we do not agree to the Individualized Education Plan and have indicated in writing any objections and alternatives. See section 11.2.a. below.

11.2.a. Written objection(s) and alternative(s)

12. Parent/Guardian Signature(s)

12.1. ______________________________

____

12.2. Date______________________________

Please return signed copy of the I.E.P. by ______________________ to contact person listed below:

Name____________________________

Address____________________________

Phone________________ Date Received__________ By______________________

APPENDIX D-5

FORM VII - Page 1 - 7/83

PERIODIC REVIEW OF INDIVIDUAL EDUCATIONAL PLAN

1. Demographic Data: DATE COMPLETED____________________

1.1. Student________________________

2. Periodic Review Goals and Objectives as Identified in the Individual Educational Plan. (Attach copy of Instructional Goal and Objectives sheet)

3. Degree to Which Periodic Review Goals and Objectives are being Achieved. (Indicate on attached copy of Instructional Goal and Objectives sheet)

4. Appropriateness of the Individual Educational Plan as it Relates to the Student's Current Needs.

5. What modifications, if any, Need to be Made in the Individual Educational Plan.

5.1

5.2.

5.3.

5.4.

6. Parental Rights Review

6.1. Date_______________

7. Parental/Guardian Response

7.1. _____I/we do agree to the Periodic Review Recommendations.

7.2. _____I/we do not agree to the Periodic Review Recommendations and have indicated in writing any objections and alternatives. See section 7.2.a. below.

7.2.a. Written objections(s) and alternative(s)

FORM VII - Page 2

8. Parent/Guardian Signature(s)

8.1. ____________________________

____

8.2. Date ______________________

Please return signed copy of the form by ________________________ to contact person listed below:

Name________________________________

Address____

Phone__________________ Date Received______________ By________________________

APPENDIX D-6

- 7/85

INSTRUCTIONAL/PLACEMENT LEVELS OF SERVICE

1. Level II: Regular Classroom
   - 1.1. Student is full-time in the regular classroom
   - 1.2. Student receives special education/related services within the regular classroom
   - 1.3. Intervention Activities
     - a. Modification of all areas of student need as indicated on the IEP in relation to the regular classroom environment.
     - b. Monitoring and documentation of consultation and activities.

2. Level III: Regular Classroom
   - 2.1. Student is half-time or more than half-time, but not full-time, in the regular classroom for instruction to include Art, Music, Phy. Ed., etc.
   - 2.2. Student receives special education/related services outside the regular classroom during the remaining instructional time.
   - 2.3. Intervention Activities
     - a. Activities included in 1.3. a and b.
     - b. Direct instruction and/or instructional remediation by the educational specialists of all areas of student need which cannot be addressed in the regular classroom environment.

3. Level IV: Special Classroom
   - 3.1. Student is half-time or more than half-time in a separate self-contained special class on a regular school campus (this also includes early childhood center-based special education/related service programs for handicapped children.
   - 3.2. Intervention Activities
     - a. Activities included in 1.3. a and b.
     - b. Activities included in 2.3. b.
     - c. Regular classroom activities for the purpose of socialization and enrichment.

4. Level V: Separate School Facility
   - 4.1. Student receives special education/related services more than half-time (including full-time) in a separate public or private day school facility for handicapped children. (This also included early childhood center-based special education/related service program for handicapped children).
   - 4.2. Intervention Activities
     - a. Activities included in 1.3. a and b.
     - b. Activities included in 2.3.b.
     - c. Activities included in 3.2.c.

5. Level VI: Residential Facility
   - 5.1. Student receives special education/related services more than half-time (including full-time) in a public or private residential facility for handicapped children.
   - 5.2. Intervention Activities
     - a. Activities included in 1.3.a and b.
     - b. Activities included liln 2.3.b.
     - c. Activities included in 3.2.c.

6. Hospital or Homebound Environment
   - 6.1. Handicapped student (as defined by federal regulations) receives special education/related services more than half-time (including full-time) in a hospital or homebound environment.
     - a. Activities included in 1.3.a and b.
     - b. Activities included in 2.3.b.
     - c. Activities included in 3.2.c.

APPENDIX D-7

FORM VIII - Page 1 - 7/85

TERMINATION/FOLLOW-UP REPORT

1. Demographic Data: DATE COMPLETED____________________

1.1. Student____________________

2. Termination Team:

2.1.

Name	Position	Address/Phone
____________	Parent/Guardian	____________ ____________
____________	Student	____________ ____________
____________	District Representative	____________ ____________
____________	Educational Specialist	____________ ____________
____________	Classroom Teacher	____________ ____________
____________	____________	____________ ____________
____________	____________	____________ ____________
____________	____________	____________ ____________
____________	____________	____________ ____________

3. Rationale for Termination (check one):

3.1. _____ Data documentation that 1) the student has achieved all I.E.P. goals and objectives, and 2) demonstrated, during a predetermined trial period, the ability to function in regular education programs without the provision of special education and/or related services. Attach copies of appropriate documents (periodic reviews, progress reports, assessments, etc.)

3.2. _____ The student has completed a secondary program and is eligible to graduate.

3.3. _____ The student exceeds school age (i.e. 21)

FORM VIII - Page 2

4. Follow-Up Activities

	Activity	Person(s) Responsible	Date Completed
4.1.			
4.2.			
4.3.			
4.4.			

5. Contact Person(s)

	Name	Address/Phone
5.1.	____________________	______________________________ ______________________________

6. Parental Rights Review

6.1. Date________________

7. Parental/Guardian Response

7.1. _____ I/we do agree to the Termination/Follow-up Report.

7.2. _____ I/we do not agree to the Termination/Follow-up Report and have indicated in writing any objections and alternatives. See section 7.2.a. below.

7.2.a. Written Objections(s) and Alternatives(s)

8. Parent/Guardian Signature(s)

8.1. ______________________________

____

8.2. Date______________________________

Please return signed copy of the form by ________________ to contact person listed below:

Name____________________________

Address____

Phone______________ Date Received____________ By____________________

9. Follow-up Review (No Later Than 12 Calendar Months from Termination Date).

9.1. Review Date___________

9.2. Review Results/Recommendations (Review of Current Status of Student)

a.

b.

c.

d.

9.3. Report Completed by________________________________

ECAP PUBLICATIONS

Early Childhood Assessment Project
University of Minnesota

No. 1 Preschool screening in Minnesota: 1982-83 by M. L. Thurlow, J. E. Ysseldyke, & P. O'Sullivan (August, 1985).

No. 2 Current screening and diagnostic practices for identifying young handicapped children by J. E. Ysseldyke, M. L. Thurlow, P. O'Sullivan, & R. A. Bursaw (September, 1985).

No. 3 Instructional decision-making practices of teachers of preschool handicapped children by J. E. Ysseldyke, P. A. Nania, & M. L. Thurlow (September, 1985).

No. 4 Exit criteria in early childhood programs for handicapped children by M. L. Thurlow, C. A. Lehr, & J. E. Ysseldyke (September, 1985).

No. 5 Predicting outcomes in a statewide preschool screening program using demographic factors by J. E. Ysseldyke & P. O'Sullivan (October, 1985).

No. 6 An ecological study of school districts with high and low preschool screening referral rates by. J. E. Ysseldyke, M. L. Thurlow, J. A. Weiss, C. A. Lehr, & R. A. Bursaw (October, 1985).

No. 7 Assessment practices in model early childhood education programs. C. A. Lehr, J. E. Ysseldyke, & M. L. Thurlow (April, 1986).

No. 8 Decision-making practices of a national sample of preschool teachers. M. L. Thurlow, P. A. Nania, & J. E. Ysseldyke (April, 1986).

No. 9 Preschool screening referral rates in Minnesota school districts across two years. R. A. Bursaw & J. E. Ysseldyke (April, 1986).

No. 10 An ecological investigation of assessment and decision making for handicapped children prior to school entrance. J. E. Ysseldyke, M. L. Thurlow, C. A. Lehr, P. A. Nania, P. J. O'Sullivan, J. A. Weiss, & R. A. Bursaw (September, 1986).

No. 11 Policy analysis of screening and referral for early childhood special education programs. J. E. Ysseldyke, M. L. Thurlow, P. J. O'Sullivan, J. A. Weiss, P. A. Nania, & C. A. Lehr (September, 1986).

No. 12 Policy analysis of diagnostic assessment in early childhood special education programs. M. L. Thurlow, J. E. Ysseldyke, C. A. Lehr, P. A. Nania, P. J. O'Sullivan, & J. A. Weiss (September, 1986).

No. 13 Policy analysis of instructional intervention and decision making in early childhood special education programs. J. E. Ysseldyke, M. L. Thurlow, P. A. Nania, P. J. O'Sullivan, J. A. Weiss, & C. A. Lehr (September, 1986).

No. 14 Policy analysis of exit decisions and follow-up procedures in early childhood special education programs. M. L. Thurlow, J. E. Ysseldyke, J. A. Weiss, C. A. Lehr, P. J. O'Sullivan, & P. A. Nania (September, 1986).